* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2129-04 State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First, Middle, Last)	OSCAR BURNELL OLSON
2. SEX	Male
3a. TIME OF DEATH	8:00 PM
3b. DATE OF DEATH (Month, Day, Yr)	August 26, 2004
4. *SOCIAL SECURITY NUMBER	470-34-8039
5a. AGE—Last Birthday (Years)	71
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	January 9, 1933
7. BIRTHPLACE (City and State or Foreign Country)	Grant County Minnesota
8a. WAS DECEDENT A U.S. VETERAN?	YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1963
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Hobart
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Rosalie Ernstes
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Industrial Engineer
12b. KIND OF BUSINESS/INDUSTRY	Automobile
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Crown Point
13d. STREET AND NUMBER	4267 Park Place
13e. ZIP CODE	46307
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	— / 7

PARENTS

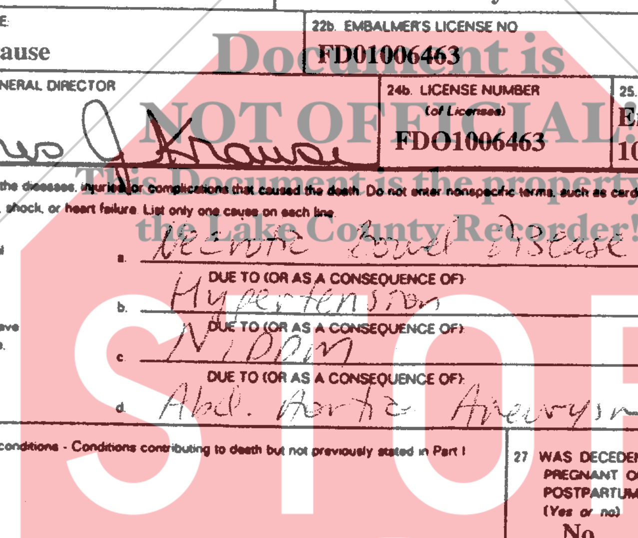
Field	Value
18. FATHER'S NAME (First, Middle, Last)	Silas Olson
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Kristi Torgesen

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	Rosalie Olson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4267 Park Place, Crown Point, IN 46307
20c. Relationship	Wife

DISPOSITION

Field	Value
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Aug 31, 2004 Lakeside Cemetery
21c. LOCATION—City or Town, State	Herman MN
22a. EMBALMER'S NAME	James J. Krause
22b. EMBALMER'S LICENSE NO.	FD01006463
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Erickson-Smith Funeral Home 0449, 107 7th St. N, Hoffman, MN 56339



CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Ischemic Bowel Disease	
DUE TO (OR AS A CONSEQUENCE OF) b.	Hypertension	
DUE TO (OR AS A CONSEQUENCE OF) c.	NIDDM	
DUE TO (OR AS A CONSEQUENCE OF) d.	Abd. Aortic Aneurysm	

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

Field	Value
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	No
AUTOPSY PERFORMED? (Yes or no)	No
WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	No

FILED
NOV 9 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

FILED FOR RECORD
LAKE COUNTY
STATE OF INDIANA

CERTIFIER

28a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated.

☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

Field	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	02002495A IN
29d. DATE SIGNED (Month, Day, Year)	9-1-04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Brett Brechner MD 10607 Randolph St. Suite A, Crown Point, IN 46307

HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	[signature] D.O.
32. DATE FILED (Month, Day, Year)	September 1, 2004

Field	Value
33. MANNER OF DEATH	☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)	
34b. TIME OF INJURY	
34c. INJURY AT WORK? (Yes or no)	
34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
SEP 01 2004

000723

Lakes of the Four Seasons Unit #4 Lot 207 Key #10-48-15 unit #11

SDH06-004 State Form 10110 (R5/1-99)