

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1674-04

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANTS

FORMANT

DISPOSITION

RECORDED RETURN TO: PROFESSIONALS TITLE SERVICES, LLC 81 CANADAWAY BIRMINGHAM, IN 46410

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Joseph P. Moser				2 SEX male		3a. TIME OF DEATH 12:53A M		3b. DATE OF DEATH (Month, Day, Yr) July 4, 2004					
4. *SOCIAL SECURITY NUMBER 316-05-4248		5a. AGE—Last Birthday (Years) 85		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) January 5, 1919		7. BIRTHPLACE (City and State or Foreign Country) Whiting Indiana			
8a. WAS DECEDENT A U.S. VETERAN? yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? Unknown		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence					
9b. FACILITY NAME (If not institution, give street and number) The Community Hospital						9c. CITY, TOWN, OR LOCATION OF DEATH Munster			9d. COUNTY OF DEATH Lake				
10. MARITAL STATUS (Specify) widowed		11. SURVIVING SPOUSE (If wife, give maiden name) none		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Lab Technician				12b. KIND OF BUSINESS/INDUSTRY Oil Refinery					
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Highland			13d. STREET AND NUMBER 3825 Jewett Street						
13e. ZIP CODE 46322		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) white		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			
18. FATHER'S NAME (First, Middle, Last) Mathias Moser						19. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Gallagher							
20a. INFORMANT'S NAME (Type/Print) Timothy J. Moser				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Rueth Drive Griffith Indiana 46319				20c. Relationship son					
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) July 8, 2004 St. Joseph Cemetery				21c. LOCATION—City or Town, State Kentland, Indiana					
22a. EMBALMER'S NAME Henry Gray				22b. EMBALMER'S LICENSE NO. FD29900123		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b. LICENSE NUMBER (of Licensee) FDO1014511		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Road Highland, Indiana 46322 FH10300021							
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. myocardial infarction b. due to (OR AS A CONSEQUENCE OF) cerebral aortic bleeding c. myocardial infarction d. myocardial infarction Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last 3 years													
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I						27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) no		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) n/a			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. MEDICAL LICENSE NO. C109251		29d. DATE SIGNED (Month, Day, Year) 7/6/04					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Fred Adler, MD, 800 McArthur Blvd., Munster, IN 46321													
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>										32. DATE FILED (Month, Day, Year) July 6, 2004			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			34a. DATE OF INJURY (Month, Day, Year)		34b. TYPE OF INJURY		34c. INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED AS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.				
			34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) STEPHEN R. STIGLICH LAKE COUNTY AUDITOR		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) JUL 06 2004 #1035 001794								
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.									