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.

Local No. 1446-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): **Claude Joseph Buirse**
2. SEX: **Male**
3a. TIME OF DEATH: **6:40** M
3b. DATE OF DEATH (Month, Day, Yr.): **May 18, 2005**
4. *SOCIAL SECURITY NUMBER: **429-70-1625**
5a. AGE—Last Birthday (Years): **65**
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr.): **September 21, 1939**
7. BIRTHPLACE (City and State or Foreign Country): **Marianna , Arkansas**
8a. WAS DECEDENT A U.S. VETERAN? **NO**
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? **N/A**
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): **St. Anthony Hospice**
9c. CITY, TOWN, OR LOCATION OF DEATH: **Crown Point**
9d. COUNTY OF DEATH: **Lake**
10. MARITAL STATUS (Specify): **Married**
11. SURVIVING SPOUSE (If wife, give maiden): **Josie**
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): **Hooker**
12b. KIND OF BUSINESS/INDUSTRY: **US Steel**
13a. RESIDENCE-STATE: **IN**
13b. COUNTY: **Lake**
13c. CITY, TOWN, OR LOCATION: **Merrillville**
13d. STREET AND NUMBER: **1937 West 86th Lane**
13e. ZIP CODE: **46410**
13f. INSIDE CITY LIMITS: [X] No [ ] Yes
13g. ON A FARM: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? **U.S.A.**
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): **Black**
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): **12**; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): **James Buirse**
19. MOTHER'S NAME (First, Middle, Maiden Surname): **Etta Walker**

INFORMANT

20a. INFORMANT'S NAME (First, Middle, Last): **Josie Buirse**
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): **1937 West 86th Lane Merrillville, IN 46410**
20c. Relationship: **Wife**

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): **May 25, 2005 Ridgelawn Cemetery**
21c. LOCATION—City or Town, State: **Gary, IN**
22a. EMBALMER: **Eddie Govain-Latimer**
22b. EMBALMER'S LICENSE NO.: **FD29700004**
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Eddie Govain-Latimer
24b. LICENSE NUMBER (of Licensee): **FD29700004**
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: **Ridgelawn Funeral Home FH10200007 4201 West Ridge Road Gary, IN 46408**

USE 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Kidney cancer with metastasis
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death

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): N
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

CERTIFIER

29a. 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: B Tan
29c. MEDICAL LICENSE NO.: 01031667
29d. DATE SIGNED (Month, Day, Year): 5/24/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type or Print): **Dr. Tara 8127 Merrillville Road Merrillville, Indiana 46410**
31. HEALTH OFFICER'S SIGNATURE: Susan M Burt D.O.
32. DATE FILED (Month, Day, Year): 5/24/2005

33. MANNER OF DEATH: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
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 DEPARTMENT.

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1