* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 2778-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. Reg # 9-474-26

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): VERNON GURITZ
2. SEX: Male
3a. TIME OF DEATH: 5:10PM
3b. DATE OF DEATH (Month Day Yr): December 4, 1995
4. SOCIAL SECURITY NUMBER: 338-12-6088
5a. AGE - Last Birthday (Years): 74
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): Apr 30, 1921
7. BIRTHPLACE (City and State or Foreign Country): BEECHER, IL
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1945
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. ANTHONY MEDICAL CENTER
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 name): HELEN MORRIS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CARPENTER
12b. KIND OF BUSINESS INDUSTRY: LOCAL UNION
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 845 ROSSLARE PLACE
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): WILLIAM GURITZ
19. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA SELK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): HELEN GURITZ
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 845 ROSSLARE PLACE, Crown Point, IN 46307
20c. Relationship: Wife

DISPOSITION

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): Dec 8, 1995 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION City or Town State: Schererville, IN
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. End stage ischemic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF) b. Coronary artery disease
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.: End stage renal disease
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): 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: [signature]
29c. MEDICAL LICENSE NO: 27841
29d. DATE SIGNED (Month Day Year): 12/7/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): TRENT ORFANOS MD, 297 FRANCISCAN DRIVE, CROWN POINT, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] Alexander B. Williams, M.D.
32. DATE FILED (Month Day Year): December 7 1995

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. DEC 07 1995 [signature] Alexander B. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER

FILED JUN 29 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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