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. 1059-00

#200538

TYPE/PRINT IN PERMANENT BLACK INK

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	LINDA KAREN LANGER
2. SEX	Female
3a. TIME OF DEATH	5:05 A M
3b. DATE OF DEATH (Month, Day, Yr)	May 1, 2000
4. *SOCIAL SECURITY NUMBER	317-38-3917
5a. AGE—Last Birthday (Years)	60
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Jan. 25, 1940
7. BIRTHPLACE (City and State or Foreign Country)	Chicago, Illinois
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	None
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	8419 Walnut Drive
9c. CITY, TOWN, OR LOCATION OF DEATH	Munster
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Frank R. Langer
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Registered Nurse
12b. KIND OF BUSINESS/INDUSTRY	Hospital
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Munster
13d. STREET AND NUMBER	8419 Walnut Drive
13e. ZIP CODE	46321
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+)	4

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Unavailable Bakke
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Elsie Nelson

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Frank R. Langer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8419 Walnut Drive, Munster, IN 46321
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	May 4, 2000 Holy Cross Cemetery
21c. LOCATION—City or Town, State	Calumet City, Illinois
22a. EMBALMER'S NAME	Larry D. Anthony
22b. EMBALMER'S LICENSE NO.	01001447
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Larry D. Anthony (signature)
24b. LICENSE NUMBER (of Licensee)	01001447
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Anthony & Dziadowicz F.H. #83002916 9445 Calumet Ave., Munster, IN 46321

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Kidney Cancer — 2 mos
DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

Field	Entry
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

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

MAY 03 2000

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	(signature)
29c. MEDICAL LICENSE NO.	01045710
29d. DATE SIGNED (Month, Day, Year)	May 3, 2000
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	M. A. Trybula, M.D., 125 E. 89th Avenue, Merrillville, Indiana 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, M.D. (signature)
32. DATE FILED (Month, Day, Year)	May 3, 2000

Field	Entry
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.	

26-35-0120-0038

FILED
FEB 27 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

004069

$11 CS

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

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Prescribed by the
State Board of Accounts
(2005)

County form 170

Declaration

Document is
NOT OFFICIAL!
This Document is the property of
the Lake County Recorder!

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do herby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number in attached document.

2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.

Signature of Declarant

FRANK R LANGER
Printed Name of Declarant