

* 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

State No.

Local No. 176906

27-17-0085-0007

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) ARTHUR C. WUNSCHEL		2. SEX Male	3a. TIME OF DEATH 1:10 PM	3b. DATE OF DEATH (Month, Day, Yr.) July 22, 2006
4. SOCIAL SECURITY NUMBER 306-03-2351	5a. AGE—Last Birthday (Years) 90	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) May 25, 1916
7. BIRTHPLACE (City and State or Foreign Country) West Hammond Illinois	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: <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) 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) Ann Spakowski	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Food Broker		12b. KIND OF BUSINESS/INDUSTRY FOOD
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hobart		13d. STREET AND NUMBER 926 W. Home Ave.
13e. ZIP CODE 46342	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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+) 7		18. FATHER'S NAME (First, Middle, Last) Arthur Henry Wunschel		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Sass		20. INFORMANT'S NAME (Type/Print) Ann R. Wunschel		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 W. Home Ave., Hobart, IN 46342		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) Jul 26, 2006 Calvary Crematory		21c. LOCATION—City or Town, State Portage IN
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FD01006463		23. WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FD01006463	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488	
26. PART I Enter the disease, 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 heart failure DUE TO (OR AS A CONSEQUENCE OF): b. arteriosclerotic heart 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				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I chronic obstructive pulmonary 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
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>Paul M. Allen MD</i>			29c. MEDICAL LICENSE NO. 01020846	29d. DATE SIGNED (Month, Day, Year) 7/25/06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donald M Phillips MD 1356 S. Lake Park Avenue, Hobart, IN 46342				
31. HEALTH OFFICER'S SIGNATURE <i>William W. Best, D.O.</i>				32. DATE FILED (Month, Day, Year) July 25, 2006
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Poisoning <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) AUG 3 1 2006	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED FILED		34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc (Specify) 17101		
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) JUL 25 2006		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 17101				

SDH06-004 STATE COUNTY AUDITOR

PEGGY HOLINGA KATONA

FILED

AUG 3 1 2006

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