

Key # 26-32-0122-0012

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THIS CERTIFIES THE FOLLOWING IS A TRUE AND
COMPLETE COPY OF DEATH ON FILE WITH THE
HAMMOND HEALTH DEPARTMENT.
Date issued
Dec. 11 2004
Hammond Health Commissioner

EMBALMER'S NAME Henry J. Blake

FUNERAL DIRECTOR'S SIGNATURE
Eileen V. de Hayne

FUNERAL HOME
No. FDH 3002885

FUNERAL DIRECTOR'S
LICENSE No. FDE 1041928

LICENSE No. FDE 1019406

INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

State No. 870

DECEASED—NAME FIRST MIDDLE LAST Louise R. Leu		SEX Female	DATE OF DEATH (MONTH, DAY, YEAR) 11-12-87
RACE—(e.g. White, Black, American Indian, etc.) White		AGE—Last Birthday (MOS, DAYS, HOURS, MINS) 75	COUNTY OF DEATH Lake
CITY, TOWN OR LOCATION OF DEATH Hammond			
HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number) St. Margaret Hospital			
7c. WAS DECEDENT EVER IN U.S. MILITARY FORCES? NO			
STATE OF BIRTH (If not in U.S.A. name country) Indiana		SURVIVING SPOUSE (If wife, give maiden name) Eugene C. Leu	
8. SOCIAL SECURITY NUMBER 316-36-7225		11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
13. RESIDENCE—STATE Indiana		14a. CITY, TOWN OR LOCATION Hammond	
15a. STREET AND NUMBER 909 - 175th Place		14b. KIND OF BUSINESS OR INDUSTRY Own Home	
15d. IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. NO			
15g. FATHER—NAME John Robinson		17. MOTHER—MAIDEN NAME Della Brown	
16. INFORMANT—NAME (Type or print) Eugene C. Leu - Husband		RELATIONSHIP Husband	
18a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		19b. CEMETERY OR CREMATORY—FUNERAL HOME Elmwood Cemetery	
DATE (MONTH, DAY YEAR) November 16, 1987		20b. FUNERAL HOME—NAME AND ADDRESS LaHayne Funeral Home, Inc., 5746 Hohman Ave., Hammond, Indiana 46320	
20a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.			
21a. Signature <i>E. M. Alt Jr.</i>		21b. DATE SIGNED (Mo., Day, Yr.) 11/14/DEC 13 2006	
21d. NAME OF ATTENDING PHYSICIAN (Type or Print) E. M. Alt Jr., M.D.		21c. HOUR OF DEATH 11:50 a.m.	
21e. MAILING ADDRESS—PHYSICIAN 7550 Hohman Avenue, Munster, Indiana 46342			
21f. HEALTH OFFICER—SIGNATURE <i>Peggy Holinga Katona</i>			
22a. IMMEDIATE CAUSE RESPIRATORY FAILURE		22b. DATE RECEIVED BY LOCAL HEALTH OFFICER NOV 16 1987	
23. INTERVAL BETWEEN ONSET AND DEATH 11/2			
PART I (a) (b) (c) CAUSE RESPIRATORY FAILURE CEREBRAL VASCULAR THROMBOSIS CEREBRAL ARTERIOSCLEROSIS			
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a) Hypostatic PNEUMONIAE - Chronic Rheumatoid Arthritis			
24. AUTOPSY (Specify Y or N) No			