* **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. 2059-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): BERT A. SPAIN
2. SEX: Male
3a. TIME OF DEATH: 1:34 PM M
3b. DATE OF DEATH (Month, Day, Yr.): May 19, 2002
4. *SOCIAL SECURITY NUMBER: 312-05-2441
5a. AGE—Last Birthday (Years): 86
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): December 9, 1915
7. BIRTHPLACE (City and State or Foreign Country): Rensselaer Indiana
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: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; ☐ OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ 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): Esther Eshleman
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Supervisor
12b. KIND OF BUSINESS/INDUSTRY: Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 430 N. Lawrence Street
13e. ZIP CODE: 46342
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?: ☒ 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): ~~12~~ College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Floyd H. Spain
19. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle E. Amsler

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Esther D. Spain
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 430 N. Lawrence Street, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

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 23, 2002 Calvary Cemetery
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 CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
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

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. Chronic lymphocytic leukemia
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

COMMUNITY TITLE COMPANY FILE NO 236267

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): 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: Mark O Carter MD
29c. MEDICAL LICENSE NO.: 01036415
29d. DATE SIGNED (Month, Day, Year): 5/21/02

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Mark O. Carter MD 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): May 27, 2002

33. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. OF INJURY:
34c. [illegible] (Yes or no):
34d. DESCRIBE HOW INJURY Ooccurred:
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.:

FILED DEC 26 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

026423

SDH06-004 State Form 10110 (R5/1-99)