ORANGE COUNTY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Local No. 96 — 31-25-0047-0021

THIS IS AN EXACT COPY OF THE CERTIFICATE OF DEATH AS IT HAS BEEN FILED WITH THE INDIANA STATE DEPARTMENT OF HEALTH. THIS IS NOT TO BE CONSIDERED A VALID COPY UNLESS SEALED WITH THE OFFICIAL RAISED SEAL OF THE ORANGE COUNTY HEALTH DEPARTMENT AND STAMPED WITH THE HEALTH OFFICER'S SIGNATURE.

SIGNATURE: Curtis C Trill MD

S-E-A-L

DATE: 5-22-98

1. DECEASED—NAME (First, Middle, Last): DONALD E. QUASEBARTH
2. SEX: MALE
3a. TIME OF DEATH: 1:50 PM
3b. DATE OF DEATH (Month, Day, Yr.): MAY 14, 1998
4. *SOCIAL SECURITY NUMBER: 307-38-2298
5a. AGE—Last Birthday (Years): 58
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): October 15, 1939
7. BIRTHPLACE (City and State or Foreign Country): FRANCISVILLE, IN.
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 0
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): ORANGE Co HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: PAOLI
9d. COUNTY OF DEATH: ORANGE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): SHIRLEY DEVRIES
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): FACTORY WORKER
12b. KIND OF BUSINESS/INDUSTRY: STEEL MILLS
13a. RESIDENCE—STATE: IN
13b. COUNTY: CRAWFORD
13c. CITY, TOWN, OR LOCATION: ECKERTY
13d. STREET AND NUMBER: 6415 W. PEDORA Rd.
13e. ZIP CODE: 47116
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 8 yrs; College (1-4 or 5+):
18. FATHER'S NAME (First, Middle, Last): WILBER PAUL QUASEBARTH
19. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA MAE HUBNAGLE
20a. INFORMANT'S NAME (Type/Print): SHIRLEY QUASEBARTH
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6415 W. PEDORA Rd. ECKERTY 47116
20c. Relationship: WIFE
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 19, 1998 SUPERIOR CREMATORY
21c. LOCATION—City or Town, State: CHARLESTOWN, IN.
22a. EMBALMER'S NAME: R.D PYKE
22b. EMBALMER'S LICENSE NO.: 0080208
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Ben Dearing
24b. LICENSE NUMBER (of Licensee): 0100508
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BROSMER-DEARING FUNERAL HOME INC. 8547 W. COLLEGE FRENCH LICK, IN 47432 — 19500022

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. CARDIAC ARRHYTHMIA — Approximate Interval Between Onset and Death: 1 HOUR

DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. CORONARY ARTERY ATHEROSCLEROSIS — YEARS

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: NONE

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): YES
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

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) as stated and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James M Jacobi FORENSIC PATHOLOGIST
29c. MEDICAL LICENSE NO.: 0102815
29d. DATE SIGNED (Month, Day, Year): 05-19-98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JAMES M. JACOBI MD P.O BOX 1281 BEDFORD, IN 47421

31. HEALTH OFFICER'S SIGNATURE: Curtis C Trill MD
32. DATE FILED (Month, Day, Year): 5-19-98

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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, or pedestrian:

FILED
MAY 31 2007
11878
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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