**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. 2223-06

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. 18-28-0178-0025

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

| 1. DECEASED—NAME (First, Middle, Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr.) |
|---|---|---|---|
| Casper B. Almaguer | Male | 5:32P M | September 17, 2006 |

| 4. *SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR Months / Days | 5c. UNDER 1 DAY Hours / Minutes | 6. DATE OF BIRTH (Mo, Day, Yr) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 354-20-8483 | 79 | | | Jan. 27, 1927 | Chicago, IL |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See instructions.) |
|---|---|---|
| Yes | 1946 | HOSPITAL: XXX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| Community Hospital | Munster | Lake |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | Rose Gonzales | Loader | Inland Steel |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| IN | Lake | Munster | 529 River Drive |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5 +) |
|---|---|---|---|---|---|---|---|
| 46321 | ☐ No XXX Yes | XXX No ☐ Yes | USA | Mexican | White | 12 | |

PARENTS

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Agapito Almaguer | Gregoria Bais |

INFORMANT

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| Rose Almaguer | 529 River Dr. Munster, Ind. 46321 | Wife |

DISPOSITION

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| XXX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) | September 22, 2006 Abraham Lincon National Cemetery | Elwood, Illinois |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| James F. Betkowski | FD09200077 | ☐ No XXX Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| James F. Betkowski | FD09200077 | Elmwood Chapel FHD# 19900052 11300 W. 97th. Ln. St. John, Ind. 46373 |

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.

| IMMEDIATE CAUSE (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
|---|---|
| a. respiratory failure DUE TO (OR AS A CONSEQUENCE OF): | |
| b. idiopathic pulmonary fibrosis 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.

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

CERTIFIER

29a. CERTIFIER (Check only one)

XX 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 | 29c. MEDICAL LICENSE NO | 29d. DATE SIGNED (Month, Day, Yr) |
|---|---|---|
| [signature] | 0103345 | 9/19/06 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. R.H. Dumont 761 45th Street Munster, Indiana 46321

31. HEALTH OFFICER'S SIGNATURE

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

32. DATE FILED (Month, Day, Year) September 20, 2006

FILED

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

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JUN 01 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

| 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? (If yes, specify driver, passenger, pedestrian, etc.) |
|---|---|
| | |



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