* **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. 118

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

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Hershel D. Yeager
2. SEX	Male
3a. TIME OF DEATH	9:20 P M
3b. DATE OF DEATH (Month, Day, Yr.)	April 28, 2007
4. *SOCIAL SECURITY NUMBER	305-20-3130
5a. AGE—Last Birthday (Years)	81
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Sep. 4, 1925
7. BIRTHPLACE (City and State or Foreign Country)	East Chicago, IN
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1950
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)	3505 Lincoln St.
9c. CITY, TOWN, OR LOCATION OF DEATH	East Chicago
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Nevermarried
11. SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Mail Carrier
12b. KIND OF BUSINESS/INDUSTRY	U.S. Postal Service
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	East Chicago
13d. STREET AND NUMBER	3505 Lincoln St.
13e. ZIP CODE	46312
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)	Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Herbert Dwyer, Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Tricia Harrison

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Rebecca Tucker
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7009 E. 1st. Ave. Gary, IN 46403
20c. Relationship	Friend

DISPOSITION

Field	Entry
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 4, 2007 Fern Oaks Cemetery
21c. LOCATION—City or Town, State	Griffith, IN
22a. EMBALMER'S NAME	Samuel Smith, Jr.
22b. EMBALMER'S LICENSE NO.	FDE01019692
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Samuel Smith Jr
24b. LICENSE NUMBER (of Licensee)	FDE01019692
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Divinity Funeral Home FH83001570 3820 Pulaski St. E.C., IN 46312

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.	Congestive Heart failure	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

FILED

DEC 06 2007

Field	Entry
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)	

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	01035958
29d. DATE SIGNED (Month, Day, Year)	May 4, 2007
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Ravi Bhagwat, M.D. 10010 Don Powers Dr. Munster, IN 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] MD
32. DATE FILED (Month, Day, Year)	5/22/07

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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, pedestrian, etc.	

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VRSD 1406-004 State Form 10110 (R5/1-99) (7/05)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT