

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to determine its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

Local No. 1300-07

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

INFORMANT

DISPOSITION

USE OF

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>EUGENE F. PUFAHL</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>8:20 P.M.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>May 21, 2007</b>
4. *SOCIAL SECURITY NUMBER <b>353-16-2766</b>		5a. AGE—Last Birthday (Years) <b>2008</b>	5b. UNDER 1 YEAR (Months, Day) <b>04/19/07</b>	5c. UNDER 1 DAY (Hours, Minutes) <b>14</b>
6. DATE OF BIRTH (Mo, Day, Yr.) <b>January 15, 1925</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>South Bend, Indiana</b>		
8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>9831 Wildwood Circle</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Rita Pratt</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Steel Salesman</b>		12b. KIND OF BUSINESS/INDUSTRY <b>International Harvester</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Munster</b>	13d. STREET AND NUMBER <b>9831 Wildwood Circle</b>	
13a. ZIP CODE <b>46321</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5 + )		18. FATHER'S NAME (First, Middle, Last) <b>Frederick - Pufahl</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel - Christiansen</b>		20. INFORMANT'S NAME (Type/Print) <b>Rita Pufahl</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9831 Wildwood Cr. Munster, IN 46321</b>		20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>May 24, 2007</b> <b>Regional Cremation Service</b>		21c. LOCATION—City or Town, State <b>Munster, Indiana</b>
22a. EMBALMER'S NAME <b>James E. Janusz</b>		22b. EMBALMER'S LICENSE NO. <b>29700059</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Janusz, Jan</i>		24b. LICENSE NUMBER (of Licensee) <b>29700059</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper F.H. Agent For Smits, DeYoung-9039 Kleinman Ave. Highland, IN 46322</b> <b>83007500</b> <b>649 E. 162nd Street South Holland, IL 604</b>
26. PART I. THIS CERTIFICATE, INCLUDING THE ABOVE IS A TRUE AND COMPLETE STATEMENT OF THE FACTS AND CAUSES OF DEATH AS KNOWN TO THE CERTIFIER. IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Lung Cancer</b> Approximate Interval Between Onset and Death <b>Months</b> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <b>MAY 13 2007</b> 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) <b>N/A</b>		28. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>N/A</b>		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.		29c. MEDICAL LICENSE NO. <b>01038072</b>		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29d. DATE SIGNED (Month, Day, Year) <b>5/22/07</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Erwin L. Robin M.D. 801 MacArthur Blvd. Munster, IN 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Susan W Best D.O.</i>				32. DATE FILED (Month, Day, Year) <b>May 23, 2007</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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) <b>008958 CS</b>		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		1100		

Parcel # 18-28-638-5

