

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 833-01

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

STATE OF INDIANA LAKE COUNTY

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED - NAME (First, Middle, Last) Gunter Holthausen		2. SEX Male		3. TIME OF DEATH 3:10 am		3b. DATE OF DEATH (Month, Day, Yr.) September 26, 2007	
4. SOCIAL SECURITY NUMBER 333-28-0191		5. AGE at Birth (Years) 79		5b. UNDER 1 YEAR Months Days Hours Minutes		6. DATE OF BIRTH (Month, Day, Year) July 02, 1928	
7. BIRTHPLACE (City and State or Foreign Country) Duisberg Germany		8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1955		9. PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Residence	
10. FACILITY NAME (If not institution, give street and number) 624 E. 92nd Avenue				9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Gerda Holl		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Foreman		12b. KIND OF BUSINESS/INDUSTRY Material Service	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Merrillville		13d. STREET AND NUMBER 624 E. 92nd Avenue	
13e. ZIP CODE 46410		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A		18. FATHER'S NAME (First, Middle, Last) Bernhard Holthausen			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Helene Rasborshek				20a. INFORMANT'S NAME (Type/Print) Gerda Holthausen			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 E. 92nd Avenue, Merrillville, IN				20c. Relationship Wife			
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) September 29, 2007 N.W. Ind. Cremation Services		21c. LOCATION - City or Town, State Crown Point, Indiana			
22a. EMBALMER'S NAME n/a		22b. EMBALMER'S LICENSE NO. n/a		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James T. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana			
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) END STAGE CARDIOMYOPATHY		b. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death 23 MO			
c. DUE TO (OR AS A CONSEQUENCE OF):		d. DUE TO (OR AS A CONSEQUENCE OF):		SEP 28 2007			
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			
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.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. MEDICAL LICENSE NO. 01631582		29d. DATE SIGNED (Month, Day, Year) 9-28-07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Lyle Munn M.D. 4321 Fir St, East Chicago, IN 46312							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. But. D.O.</i>							
32. DATE FILED (Month, Day, Year) September 29, 2007		33. MANNER OF DEATH <input checked="" 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 017564	
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) CS			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) September 26, 2007				34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. 11- RB			

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Broadfield Townhomes Add Block 3 E'y Part of lot 29 45-12-27-377-006.000-030

