



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

KEY

45-09-30-324-022-000-018

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018

Local No.....

State No.....

1. Decedent's Legal Name (First, Middle, Last) Russell A Kraft				1a. Maiden Last Name (If Female)		2. Sex Male		3. Time Of Death 3:30 AM		4. Date Of Death (Month/Day/Year) January 25, 2009		
5. Social Security Number 308-46-6473		6a. Age - Yrs 64		6b. Under 1 Year Months		6c. Under 1 Month Days		6d. Under 1 Day Hours		6e. Under 1 Hour Minutes		
7. Date Of Birth (Month/Day/Year) November 11, 1944		8. Birthplace (City And State Or Foreign Country) Gary, Indiana										
9. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival				10a. If Death Occurred Somewhere Other Than A Hospital: <input checked="" type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)				
11. Facility Name (If Not Institution, Give Street And Number) Horton VNA Hospice												
12. City Or Town, State, And Zip Code Valparaiso Indiana						13. County Of Death Porter			14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name Jacqueline A Kraft				15a. (If Wife) Give Maiden Last Name Coons				16. Decedent's Usual Occupation Retired Police Officer		17. Kind Of Business/Industry Police man		
18. Residence - State Indiana			18a. County Lake			18b. City Or Town Hobart			18d. Apt. No.		18e. Zip Code 46342	
18c. Street And Number 141 Rush Court			18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			19. Decedent's Education 12+		20. Decedent Of Hispanic Origin No		21. Decedent's Race White		
22. Father's Name (First, Middle, Last) Clarence R Kraft				23. Mother's Name (First, Middle, Last) Mary Jane Kraft				23a. Mother's Maiden Last Name Wineiger				
24. Informant's Name Jacqueline A Kraft			24a. Relationship To Decedent Wife			24b. Mailing Address (Street And Number, City, State, Zip Code) 141 Rush Ct - Hobart, Indiana 46342						
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)				25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) Abraham Lincoln Memorial Cemetery, Ellettswood, Illinois				25c. Location - City, Town, And State				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Kraft Funeral Services and Crematory, Inc., 370 North County Line Rd, Hobart, IN						27a. Funeral Home License Number: FA10000005				
27b. Signature Of Indiana Funeral Service Licensee: <i>[Signature]</i>						27c. License Number (Of Licensee): FD 29300105						
28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. CARCINOMA OF BLADDER Due To (Or As A Consequence Of): B. _____ Due To (Or As A Consequence Of): C. _____ Due To (Or As A Consequence Of): D. _____ Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I.												
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						30. Were Autopsy Findings Available To Complete The Cause Of Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year				33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined						
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)				37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number				38c. Apt. No.		38d. Zip Code		
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)						
41. Signature, Of Person Certifying Cause Of Death: <i>[Signature]</i>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer						
43. Name, Address And Zip Code Of Person Certifying Cause Of Death						44. License Number 01030107A		45. Date Certified 2-5-09				
46. Additional Funeral Service Provider:						47. *Akas:						
48. Signature of Local Health Officer: <i>[Signature]</i>						49. For Registrar Only - Date Filed (Month/Day/Year): February 17, 2009						

STOP
This Document is the property of
the Lake County Recorder
FILED
APR 01 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

2009-021033
MICHAEL A. BROOKS
RECORDER
2009 APR -1 AM 10:43
FILED FOR RECORD
LAKE COUNTY INDIANA
Approximate Interval: Onset To Death
MONTHS

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CA