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. 2857-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

Parcel # 45-11-14-330-014.000-036

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED–NAME (First, Middle, Last)	Dean H. Drenckpohl
2. SEX	Male
3a. TIME OF DEATH	3:50P.M
3b. DATE OF DEATH (Month, Day, Year)	November 27,2007
4. *SOCIAL SECURITY NUMBER	352-16-9005
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)	April 24,1926
7. BIRTHPLACE (City and State or Foreign Country)	Centralia, IL
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	Unavailable
9a. PLACE OF DEATH (Check only one. See instructions.)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number)	The Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	Munster
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Josephine O'Brien
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Accountant
12b. KIND OF BUSINESS/INDUSTRY	Railroad
13a. RESIDENCE — STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Schererville
13d. STREET AND NUMBER	7434 Winchester Lane
13e. ZIP CODE	46375
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Harold C. Drenckpohl
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Florence Broeker

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Josephine Drenckpohl
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code)	7434 Winchester Ln. Schererville, IN 46375
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	December 3, 2007 Heritage Crematory
21c. LOCATION—City or Town, State	Portage, Indiana
22a. EMBALMER'S NAME:	Dan Hillegonds
22b. EMBALMER'S LICENSE NO.	IL 034-012384
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FDO 1000857
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	LaHayne FH19400005 6955 Southeastern Hammond, IN for Schroeder-Lauer FH 3227 Ridge Lansing, IL 60438

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. Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Brain Tumor
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.

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No)	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

CERTIFIER

29a. CERTIFIER (Check only one)
- [X] 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.	02001332
29d. DATE SIGNED (Month, Day, Year)	11/29/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	K. Oetter, DO 505 W. Lincoln Highway Schererville, IN 46375

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Susan W Best, D.O.
32. DATE FILED (Month, Day, Year)	November 29, 2007

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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FILED MAY 07 2009 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

SDH06-004 State Form 10110 (R5/1-99)