INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

876853

Local No 208-08 State No

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time of Death	4. Date of Death (Month/Day/Year)
Francis W. Bieker	N/A	Male	2 :20 PM	January 21, 2008

5. Social Security Number	6a. Age - Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
[redacted]-0349	89.00	Months	Days	Hours	Minutes	August 11, 1918	St. John, IN

9. Ever In U.S. Armed Forces? ☒ Yes ☐ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number)
933 High Meadow Dr.

FILED
MAY - 6 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

12. City Or Town, State, and Zip Code	13. County Of Death	14. Marital Status At Time Of Death
Crown Point IN 46307-	Lake	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
N/A	N/A	Contractor	Construction

18. Residence - State	18a. County	18b. City Or Town
Indiana	Lake	Crown Point

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
933 High Meadow Dr.		4630-	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
10	N/A	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
Frank Bieker	Clara Bieker	Bohling

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
Richard Bieker	Son	925 High Meadow Dr. Crown Point, IN 46307-

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):	Calumet Park Cemetery	Merrillville, Indiana

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	Geisen Funeral Centre 606 E. 113th Ave. Crown Point IN 46307-	FH10700031

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
X Larry Geisen	FD09000013

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2009 MAY 8 AM 9:31 MICHAEL A. BROWN RECORDER

Cause Of Death (See Instructions And Examples)

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.

		Due To (Or As A Consequence Of):	Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. Myelodysplastic Syndrome		2yrs
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	B.		
	C.		
	D.		

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? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☒ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☐ No ☒ Unknown

32. If Female: ☒ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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?
			☐ Yes ☐ 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: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: X

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
Eduardo Fletes MD 297 Franciscan Dr. Suite 104, Crown Point 46307	01049249	X 01/23/2008

46. Additional Funeral Service Provider:	47. *Akas: 003406

48. Signature of Local Health Officer:	49. For Registrar Only - Date Filed (Month/Day/Year):
Susan W Burt D.O.	January 23, 2008

State Form 10110 (R7/9-07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7 1-10

TICOR CP 92 9-3126

45-16-103-008.000-012