* 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. 625

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Aug. 17, 2001 — Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 62009044

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	RICHARD J. HAHN
2. SEX	MALE
3a. TIME OF DEATH	7:59 AM
3b. DATE OF DEATH (Month, Day, Yr)	AUG 8, 2001
4. *SOCIAL SECURITY NUMBER	304-48-1054
5a. AGE—Last Birthday (Years)	55
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	JAN 3, 1946
7. BIRTHPLACE (City and State or Foreign Country)	HAMMOND IN
8a. WAS DECEDENT A U.S. VETERAN?	NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST MARGARET MERCY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH	HAMMOND
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	SINGLE
11. SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	LABORER
12b. KIND OF BUSINESS/INDUSTRY	CONSTRUCTION
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HAMMOND
13d. STREET AND NUMBER	1239 150TH STREET
13e. ZIP CODE	46327
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	MATTHEW HAHN
19. MOTHER'S NAME (First, Middle, Maiden Surname)	HELEN BILAR

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	MATTHEW HAHN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1239 150TH ST HAMMOND IN 46327
20c. Relationship	FATHER

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	AUG 14, 2001 HOLY CROSS CEMETERY
21c. LOCATION—City or Town, State	CALUMET CITY IL
22a. EMBALMER'S NAME	JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO	1004194
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	1005491
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	LESNIAK FH 3001601 4918 MAGOUN E. CHICAGO IN 4631

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	ATHEROSCLEROTIC HEART DISEASE	YEARS
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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)	NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	NO

CERTIFIER

29a. CERTIFIER (Check only one)

- ☒ 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	S Barnabas M.D. ATTENDING PHYSICIAN
29c. MEDICAL LICENSE NO	036-06142
29d. DATE SIGNED (Month, Day, Year)	8/10/2001 (August)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	SATISH BARNABAS 5015 N. PAULINA CHICAGO IL 60640

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Franklin D. Bremuda M.D.
32. DATE FILED (Month, Day, Year)	August 17, 2001

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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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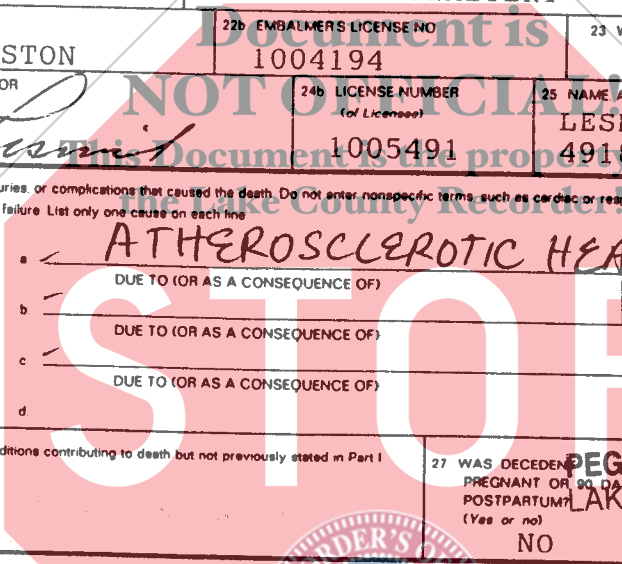
SDH06-004 State Form 10110 (R5/1-99)



Chicago Title Insurance Company

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