ATTENTION ESTATE: The Social Security # is ing requested by this state agency in order to irsue its statutory responsibility. Disclosure is luntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

ocal No. 0007-05 State No.

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

YPE/PRINT IN ERMANENT LACK INK

1. DECEASED—NAME (First, Middle, Last): Guy Raymond Haskell
2. SEX: Male
3a. TIME OF DEATH: 05:20 AM
3b. DATE OF DEATH (Month, Day, Yr.): January 1, 2005
4. *SOCIAL SECURITY NUMBER: 308-32-3833
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 29, 1933
7. BIRTHPLACE (City and State or Foreign Country): Lowell IN
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1966
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☒ Nursing Home ☐ Other (Specify) ☐ Residence

ECEDENT

9b. FACILITY NAME (If not institution, give street and number): St. Anthony Inpatient Hospice
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Angela Mueller
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Diesel Mechanic
12b. KIND OF BUSINESS/INDUSTRY: Heavy Equipment
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lowell
13d. STREET AND NUMBER: 286 Arrowhead
13e. ZIP CODE: 46356
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Caucasian
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +): 2

ARENTS

18. FATHER'S NAME (First, Middle, Last): Guy Haskell
19. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Gerner

FORMANT

20a. INFORMANT'S NAME (Type/Print): Angela Haskell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 286 Arrowhead, Lowell, In 46356
20c. Relationship: Wife

SPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jan 5, 2005 Heritage Crematory
21c. LOCATION—City or Town, State: Portage IN
22a. EMBALMER'S NAME: Molly E. Hawkins
22b. EMBALMER'S LICENSE NO.: FD09200061
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Molly E Hawkins
24b. LICENSE NUMBER (of Licensee): FD09200061
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home FH83004277 604 E. Commercial Ave. Lowell, IN 46356

USE OF ATH

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.	End Stage Renal disease	months
DUE TO (OR AS A CONSEQUENCE OF): b.		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

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):
☒ 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.

RTIFIER

29b. SIGNATURE AND TITLE OF CERTIFIER: George Babchuck
29c. MEDICAL LICENSE NO.: 01031717
29d. DATE SIGNED (Month, Day, Year): 1/5/05.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. George Babchuck 1121 S. Indiana Ave., Crown Point, IN 46307

ALTH FICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burton MD
FILED SEP 11 2005 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR 016385
32. DATE FILED (Month, Day, Year): January 5, 2005

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.:

#3295 55

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