

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1594-97

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) WILLIAM SIEVERN		2. SEX MALE	3a. TIME OF DEATH 4:55 P.M.	3b. DATE OF DEATH (Month, Day, Yr) AUGUST 1, 1997
4. SOCIAL SECURITY NUMBER 314-24-3388	5a. AGE—Last Birthday 69	5b. UNDER 1 YEAR Months: 05 Days: 00	5c. UNDER 1 DAY Hours: 00 Minutes: 00	6. DATE OF BIRTH (Mo, Day, Yr) NOVEMBER 16, 1927
7. BIRTHPLACE (City and State or Foreign Country) CARY, INDIANA		8a. WAS DECEDENT A U.S. VETERAN? YES		
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1949		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> RESIDENCE <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) 10005 HUNTERS RUN		9c. CITY, TOWN, OR LOCATION OF DEATH ST. JOHN	9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) RITA POQUETTE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) FOREMAN RETIRED		12b. KIND OF BUSINESS/INDUSTRY HECKETT DIV. OF HARSCO
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION ST. JOHN		13d. STREET AND NUMBER 10005 HUNTERS RUN
13a. ZIP CODE 46373	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) WHITE
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) WILLIAM F. SIEVERN		19. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL NORA JACOBS		
20a. INFORMANT'S NAME (Type/Print) RITA SIEVERN		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10005 HUNTERS RUN ST. JOHN, IND. 46373	20c. Relationship WIFE	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) AUGUST 3, 1997 N.W. IND. CREMATION SERVICE		21c. LOCATION—City or Town, State CROWN POINT, INDIANA
22a. EMBALMER'S NAME NONE		22b. EMBALMER'S LICENSE NO. N/A	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Eli Dujko</i>		24b. LICENSE NUMBER (of Licensee) FDO1008300	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307	
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. THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE DISCUSSIVE REPORT IN FILE WITH THE LAKE COUNTY HEALTH DEPT. IMMEDIATE CAUSE (Final disease or condition resulting in death): Cardio Arrest a. DUE TO (OR AS A CONSEQUENCE OF): Respiratory Failure b. DUE TO (OR AS A CONSEQUENCE OF): Metastatic cancer c. DUE TO (OR AS A CONSEQUENCE OF): PEGGY HOLINGA KAPONA LAKE COUNTY HEALTH OFFICER d. AUG 12 1997				Approximate Interval Between Onset and Death minutes days weeks
PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I. LAKE COUNTY HEALTH COMMISSIONER		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.		29c. MEDICAL LICENSE NO. 0200296		29d. DATE SIGNED (Month, Day, Year) 8/2/97
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steven A. Blum</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Steven A. Blum 706 Ridge Road Muncie Indiana 46321		
31. HEALTH OFFICER'S SIGNATURE <i>Alfred B. Holing, MD</i>		32. DATE FILED (Month, Day, Year) August 21, 1997		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED CS		34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 013209		
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. 1100				

File # 45-1-32-480-020-000-035
 SEP 29 2009
 LAKE COUNTY HEALTH DEPT

