

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. 1782-05

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) Herschel H. Bengel		2 SEX Male	3a TIME OF DEATH 4:50A M	3b DATE OF DEATH (Month, Day, Yr.) July 3, 2005
4 *SOCIAL SECURITY NUMBER 407-42-8703	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Oct. 26, 1934
7 BIRTHPLACE (City and State or Foreign Country) London, KY	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1959	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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 9925 Merrillville Road	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) Treth Minton	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steel Worker	12b KIND OF BUSINESS/INDUSTRY Steel	13a RESIDENCE—STATE IN	
13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Crown Point	13d STREET AND NUMBER 9925 Merrillville Road	13e ZIP CODE 46307	
13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12
18 FATHER'S NAME (First, Middle, Last) Mack Bengel		19 MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Bundy		
20a INFORMANT'S NAME (Type/Print) Tretha Bengel		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9925 Merrillville RD Crown Point IN 46307	20c Relationship Wife	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) July 5, 2005 Heritage Crematory		21c LOCATION (City or Town, State) Portage, IN
22a EMBALMER'S NAME Not Embalmed		22b EMBALMER'S LICENSE NO. NA	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>William E. Burdan</i>		24b LICENSE NUMBER (of Licenses) FD01007697	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burdan Funeral Home #83002461 12901 Wicker Ave Cedar Lake IN 46508	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Metastatic gastric cancer DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)				
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) NA	
29e CERTIFIER (Check only one) <input 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, 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, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.				
29b SIGNATURE AND TITLE OF CERTIFIER <i>B. Ten MD</i>		29c MEDICAL LICENSE NO. 01031667	29d DATE SIGNED (Month, Day, Year) 7/20/05	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. P. J. TARA 8127 MERRILLVILLE RD. MERR. IND 46411				
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. But D.O.</i>				32 DATE FILED (Month, Day, Year) July 19, 2005
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		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) 15011
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian. 000198		