

* 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

Local No. 133-96

State No. 45-11-30-227-001-000-055

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

PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

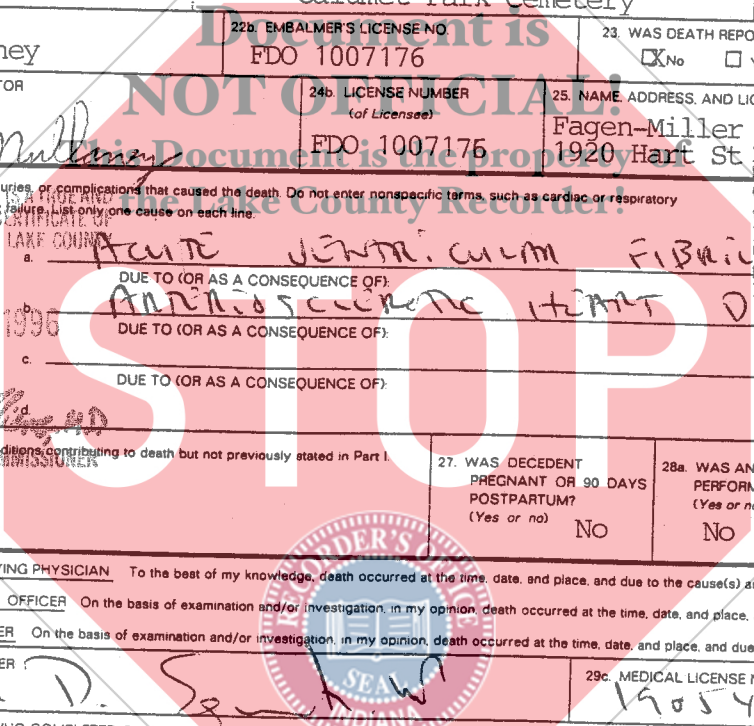
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Stephen J. Peters		2. SEX Male	3a. TIME OF DEATH 11:56 AM	3b. DATE OF DEATH (Month, Day, Yr) June 13, 1996	
4. *SOCIAL SECURITY NUMBER 312-09-9169	5a. AGE—Last Birthday (Years) 79	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) May 10, 1917	
7. BIRTHPLACE (City and State or Foreign Country) Dunlow, Pennsylvania	8a. WAS DECEDENT A U.S. VETERAN? Yes				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) St Margaret Mercy Hospital—South		9c. CITY, TOWN, OR LOCATION OF DEATH Dyer	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Isabella P. Pulaski	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Operator		12b. KIND OF BUSINESS/INDUSTRY Scrap Metal	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION St John		13d. STREET AND NUMBER 13051 W. 85th Ave	
13e. ZIP CODE 46373	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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 (0-12) 12 College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) George Peters			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Alloe		20a. INFORMANT'S NAME (Type/Print) Isabella P. Peters			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13051 W. 85th Ave St John, Indiana 46373		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input 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) June 17, 1996 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, Indiana	
22a. EMBALMER'S NAME Edward F. Mullaney		22b. EMBALMER'S LICENSE NO. FDO 1007176		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i>		24b. LICENSE NUMBER (of licensee) FDO 1007176	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes Inc 1920 Hart St Dyer, Indiana 46311 FH83001504		
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 OF DEATH (condition resulting in death) ACUTE CENTR. CULM FIBRIL DUE TO (OR AS A CONSEQUENCE OF) ANDROGENIC HEART DISEASE JUN 14 1996 CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST ANDROGENIC HEART DISEASE 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)		
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.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles D. Egnatz</i>			29c. MEDICAL LICENSE NO. 19054	29d. DATE SIGNED (Month, Day, Year) June 14, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Charles D. Egnatz MD, 1326 US Rte 30 Schererville, Indiana 46375					
31. HEALTH OFFICER'S SIGNATURE <i>Charles D. Egnatz MD</i>			32. DATE FILED (Month, Day, Year) 6/14/96		
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 MAR 10 2010
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34f. NUMBER OF PERSONS IN HOME (Specify)			
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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 OFFICE OF THE RECORDER
 LAKE COUNTY, INDIANA
 FOR RECORD

FILED

**PEGGY HOLINGA KAPONA
LAKE COUNTY AUDITOR**

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