* 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. 2330-97 ... State No. ...

40559

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Eugene R. Wold
2. SEX: Male
3a. TIME OF DEATH: 5P.M.
3b. DATE OF DEATH (Month, Day, Yr): Nov. 6, 1997
4. *SOCIAL SECURITY NUMBER: 359-18-2490
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Dec. 17,1927
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Il.
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: NA
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: XX Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Southlake Care Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Rita McNally
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Plant Manager
12b. KIND OF BUSINESS/INDUSTRY: Manufacturing
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Munster
13d. STREET AND NUMBER: 415 Old Stone Unit#4
13e. ZIP CODE: 46321
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: X No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Richard Wold
19. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Frykblom

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Rita Wold
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 Old Stone Rd. Munster, In.46321
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Assumption Cemetery Nov. 11, 1997
21c. LOCATION—City or Town, State: Glenwood, Illinois
22a. EMBALMER'S NAME: Daniel Holste
22b. EMBALMER'S LICENSE NO.: Il 034-014638
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01000857
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LaHayne FH8300285 46320 5746 Hohman Ave. Hammond,In
Schroeder-Lauer F.H. 3227 Ridge Rd. Lansing,Il.

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Parkinson's Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): no

CERTIFIER

29a. CERTIFIER (Check only one): XX 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.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. MEDICAL LICENSE NO.: 01025591
29d. DATE SIGNED (Month, Day, Year): 11-6-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Alexander Stemer M.D. 45th Ave. & Calumet Ave. Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
FILED
32. DATE FILED (Month, Day, Year): November 11, 1997

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.

JUL 15 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR
#11 MT
1015424
053914
HOLD FOR MERIDIAN TITLE CORP
2010 040126 FILED FOR RECORD LAKE COUNTY INDIANA MICHAEL A. BROWN RECORDER 2010 JUL 15 AM 10: 26

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1