

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue 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. 0061-05

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

45-08-30-201-002-006-003

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Martin Schuster</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>4:30 P.M.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>January 6, 2005</b>
4. SOCIAL SECURITY NUMBER <b>313-07-5215</b>	5a. AGE—Last Birthday (Years) <b>86</b>	5b. UNDER 1 YEAR Months: Days	5c. UNDER 1 DAY Hours: Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) <b>April 9, 1918</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>New Castle, Pennsylvania</b>	8a. WAS DECEASED A U.S. VETERAN? <b>Yes</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input 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) <b>Methodist Hospital Southlake Campus</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>		9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Widowed</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>-----</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Pipefitter Foreman</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Steel Industry</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Gary - Calumet Township</b>		13d. STREET AND NUMBER <b>5436 W. 41st Avenue</b>
13e. ZIP CODE <b>46408</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEASED 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) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		18. FATHER'S NAME (First, Middle, Last) <b>Martin Schuster</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anne Wenzel</b>		20a. INFORMANT'S NAME (Type/Print) <b>Priscilla Masters</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1129 Fuller Street, Cincinnati OH 45202</b>		20c. Relationship <b>Daughter</b>		
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) <b>January 8, 2005 Calumet Park Cemetery</b>		21c. LOCATION (City or Town, State) <b>Merrillville, Indiana</b>
22a. EMBALMERS NAME <b>Ronald A. Reed</b>		22b. EMBALMER'S LICENSE NO. <b>FDO1001081</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ronald A. Reed</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO1005912</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410</b>
26. PART I. Enter the disease, 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) <b>Head Trauma</b>		DUE TO (OR AS A CONSEQUENCE OF) <b>Congestive Heart Failure</b>		Approximate Interval Between Onset and Death <b>2 DAYS</b>
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		DUE TO (OR AS A CONSEQUENCE OF) <b>MAY 25 2011</b>		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I		27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>
		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of your knowledge, the cause and date, 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>Bharat H. Barai</i>			29c. MEDICAL LICENSE NO. <b>01030107</b>	29d. DATE SIGNED (Month, Day, Year) <b>01-10-2005</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Bharat H. Barai, M.D., 200 E. 89th Avenue, Suite 2A, Merrillville, Indiana 46410</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. But...</i>				32. DATE FILED (Month, Day, Year) <b>January 11, 2005</b>
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) <b>11 AD CS</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>001851</b>		