





**INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH**

**Local No 002762**

**EDR No 00000278071**

**State No 039334**

1. Decedent's Legal Name (First, Middle, Last) <b>NORMAN PHILIP KERSTEN</b>				1a. Maiden Name (If female)		2. Sex <b>MALE</b>	3. Time Of Death <b>00:04</b>	4. Date Of Death (Month/Day/Year) <b>09/02/2012</b>	
5. Social Security Number <b>353-36-5166</b>		6a. Age - Yrs <b>68</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>09/01/1944</b>		8. Birthplace (City and State or Foreign Country) <b>CHICAGO, IL</b>
9. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival				10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street and Number) <b>ST ANTHONY MEDICAL CENTER OF CROWN POINT</b>									
12. City Or Town, State, And Zip Code <b>CROWN POINT, IN, 46307</b>					13. County Of Death <b>LAKE</b>			14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name <b>ARLENE KERSTEN</b>			15a. (If Wife) Give Maiden Last Name <b>BLIZNIAK</b>			16. Decedent's Usual Occupation <b>STEL WORKER FORMAN</b>		17. Kind Of Business/Industry <b>US STEEL</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>			18b. City Or Town <b>CROWN POINT</b>				
18c. Street And Number <b>9003 MATHEWS STREET</b>						18d. Apt. No.	18e. Zip Code <b>46307</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>			20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>			21. Decedent's Race <b>White</b>			
22. Father's Name (First, Middle, Last) <b>ERICH KERSTEN</b>				23. Mother's Name (First, Middle, Last) <b>JANE KERSTEN</b>			23a. Mother's Maiden Last Name <b>KALECKI</b>		
24. Informant's Name <b>ARLENE KERSTEN</b>		24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>9003 MATHEWS STREET, CROWN POINT, IN 46307</b>					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>HEIGHTS CREMATORY</b>			25c. Location - City, Town, And State <b>CHICAGO HEIGHTS, IL</b>				
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>LINCOLN RIDGE FUNERAL HOME, 7607 W. LINCOLN HIGHWAY, CROWN POINT, IN 46307</b>					27a. Funeral Home License Number: <b>FH88800070</b>		
27b. Signature Of Indiana Funeral Service Licensee: <b>ELI VUJKO, BY ELECTRONIC SIGNATURE</b>		27c. License Number (Of Licensee): <b>FD01008300</b>							
28. Part I. Enter The <u>Chain Of Events</u> - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.									
Immediate Cause (Final Disease Or Condition Resulting In Death)				A. <b>VASCULAR COLLAPSE</b>		Due to (Or As A Consequence Of):		UNKNOWN	
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last				B. <b>DUE TO ARTERIOSCLEROTIC HEART AND VASCULAR DISEASE</b>		Due to (Or As A Consequence Of):			
				C.		Due to (Or As A Consequence Of):			
				D.		Due to (Or As A Consequence Of):			
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined				
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
38. Location Of Injury - State		38a. City Or Town			38b. Street & Number		38c. Apt. No.	38d. Zip Code	
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
41. Signature, Of Person Certifying Cause Of Death: <b>GEORGE DELIPOULOS, BY ELECTRONIC SIGNATURE</b>						42. Certifier (Check Only One) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>GEORGE DELIPOULOS, 2900 W. 93RD AVENUE, CROWN POINT, IN 46307</b>						44. License Number		45. Date Certified <b>09/05/2012</b>	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>SEP 07 2012</b>			
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)									