



STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Doris J. Bagull, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 1st day of June, 2016.

My commission expires: 9/6/2022



**Document is**

**NOT OFFICIAL!**

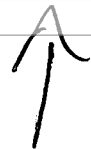
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Resident of: Lake County, Indiana

**STOP**

"I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law."

This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800



INDIANA STATE BOARD OF HEALTH

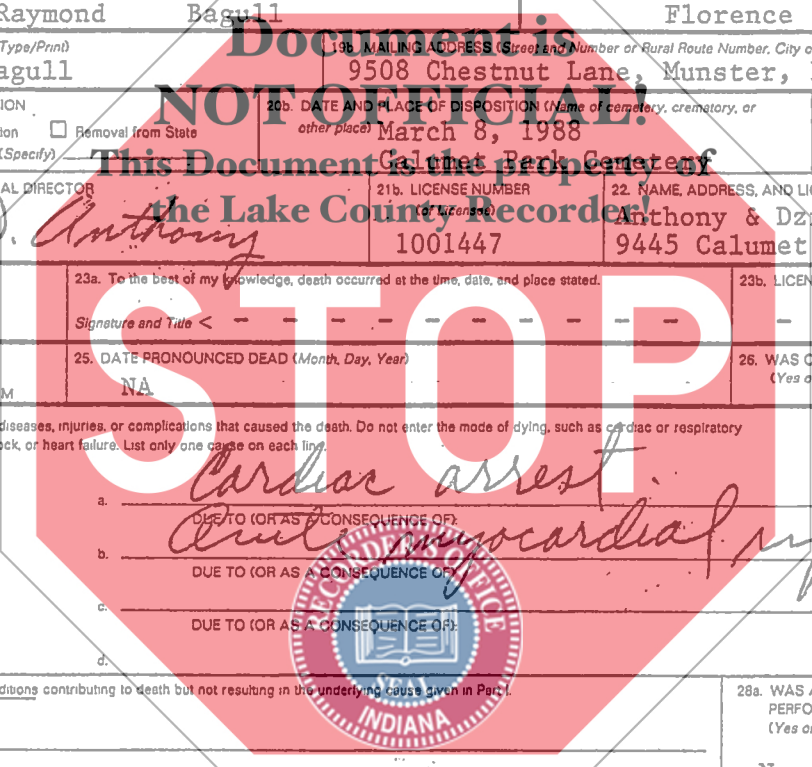
CERTIFICATE OF DEATH

Local No. 486-88

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME FIRST MIDDLE LAST <b>Robert J. Bagull</b>	2 SEX <b>Male</b>	3 DATE OF DEATH (Mo., Day, Yr) <b>March 4, 1988</b>
4 SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years) <b>47</b>	5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) <b>Aug 29, 1940</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Illinois</b>
8. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>No</b>	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"/> Residence <input type="checkbox"/> Other (Specify)	
9b. FACILITY NAME (If not institution, give street and number) <b>Community Hospital</b>	9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>	9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS—Married Never Married, Widowed, Divorced (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Doris J. Heemstra</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Manager - Process Control</b>
12b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>	13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>
13c. CITY, TOWN, OR LOCATION <b>Munster</b>	13d. STREET AND NUMBER <b>9508 Chestnut Lane</b>	13e. ZIP CODE <b>46321</b>
13f. FARM <b>No</b>	13g. ZIP CODE <b>46321</b>	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:
15 RACE—American Indian, Black, White, etc (Specify) <b>White</b>	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Raymond Bagull</b>	18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Conley</b>	
19a. INFORMANT'S NAME (Type/Print) <b>Doris J. Bagull</b>	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9508 Chestnut Lane, Munster, IN 46321</b>	19c. Relationship <b>Wife</b>
20a. 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)	20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>March 8, 1988</b>	20c. LOCATION—City or Town, State <b>Merrillville, Indiana</b>
21a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>	21b. LICENSE NUMBER <b>1001447</b>	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Anthony &amp; Dziadowicz F.H. 3002916 9445 Calumet Ave, Munster, IN 46321</b>
23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title < - - - - -	23b. LICENSE NUMBER - - - - -	23c. DATE SIGNED (Month, Day, Year) - - - - -
24. TIME OF DEATH <b>7:06 PM</b>	25. DATE PRONOUNCED DEAD (Month, Day, Year) <b>NA</b>	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) <b>Yes</b>
27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiac arrest.</b> <b>Due to (OR AS A CONSEQUENCE OF) acute myocardial infarction.</b>	Approximate Interval Between Onset and Death	
27. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	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)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.	29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. C. Mason, M.D.</i>	29c. LICENSE NUMBER <b>01017753B</b>
29d. DATE SIGNED (Month, Day, Year) <b>3/7/88</b>	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>J.C. MASON, M.D. 7905 Calumet Ave, Munster, IN 46321</b>	
31. HEALTH OFFICER'S SIGNATURE <i>Charles Johnson</i>	32. DATE FILED (Month, Day, Year) <b>MAR 7 1988</b>	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homocide	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)		



DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY