# INDIANA STATE BOARD OF HEALTH

Local No. 1574-88 **990503** CERTIFICATE OF DEATH State No.

Rees Funeral Home 600 W Ridge Rd Hobart

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1. DECEASED—NAME (First / Middle / Last) | 2. SEX | 3. DATE OF DEATH (Mo. Day. Yr.) |
|---|---|---|
| BETTY J. SHALAPSIK | Female | July 28, 1988 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR (Months / Days) | 5c. UNDER 1 DAY (Hours / Minutes) | 6. DATE OF BIRTH (Month, Day, Year) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 316-74-9999 | 66 | | | 4-7-1922 | HERON, INDIANA |

8. YEAR LAST SERVED IN U.S. ARMED FORCES?

9a. PLACE OF DEATH (Check only one. See instructions)
HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| ST. MARY MEDICAL CENTER | HOBART | LAKE |

| 10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | MICHAEL E. SHALAPSIK | HOMEMAKER | NONE |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| INDIANA | LAKE | HOBART | 619 NORTH LAKE PARK AVENUE |

| 13e. INSIDE CITY LIMITS? (Yes or no) | 13f. FARM | 13g. ZIP CODE | 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 15. RACE—American Indian, Black, White, etc. (Specify) | 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) |
|---|---|---|---|---|---|---|
| YES | NO | 46342 | [X] No [ ] Yes Specify: | WHITE | 12 | |

**PARENTS**

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| ANDREW J. CHILDERS (DECEASED) | NORA MAE METCALF (DECEASED) |

**INFORMANT**

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 19c. Relationship |
|---|---|---|
| MICHAEL E. SHALAPSIK | 619 NORTH LAKE PARK AVENUE, HOBART, IN 46342 | SPOUSE |

**DISPOSITION**

| 20a. METHOD OF DISPOSITION | 20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 20c. LOCATION—City or Town, State |
|---|---|---|
| [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) | August 1, 1988 EVERGREEN CEMETERY | HOBART, INDIANA |

| 21a. SIGNATURE OF FUNERAL DIRECTOR | 21b. LICENSE NUMBER (of Licensee) | 22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Gerald V. Rees | FDE1041083 | REES FUNERAL HOME- FDH3003069 600 WEST OLD RIDGE RD., HOBART, IN 463 |

**PRONOUNCING PHYSICIAN ONLY**

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

| Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death | 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 | 25. DATE PRONOUNCED DEAD (Month, Day, Year) | 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) |
|---|---|---|
| 12:15A M | JULY 28, 1988 | NO |

**CAUSE OF DEATH**

SEE INSTRUCTIONS

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardio-pulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Acute renal failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Malignant lymphoma-AUG
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. [illegible] PERFORMED? [X] NO

28b. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO

FILED JUL 29 1988 LAKE COUNTY HEALTH COMMISSION

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HLTH DEPT.

AUDITOR LAKE COUNTY

LILLIAN A. BLASTICK RECORDER, LAKE COUNTY CROWN POINT, INDIANA 46307 AUG 15 1988

**SEE INSTRUCTIONS**

**CERTIFIER**

29a. CERTIFIER (Check only one)

[X] 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.

[ ] 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.

[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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 | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robert Wylie MD | #20894 | 7/28/88 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
ROBERT WYLIE MD, 1400 S. LAKE PARK AVE. SUT 500, HOBART, INDIANA 46342

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) July 29, 1988

**CORONER OR MEDICAL EXAMINER USE ONLY**

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined | | | | |

| 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) |
|---|---|
| | |

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