

**PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH**

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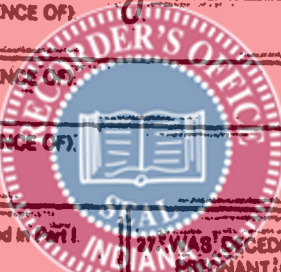
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CERTIFICATE OF DEATH

State No:

1 DECEASED—NAME (First, Middle, Last) Frank Lopez		2 SEX Male	3a TIME OF DEATH 11:47 a.m.	3b DATE OF DEATH (Month, Day, Year) December 4, 1990
4 SOCIAL SECURITY NUMBER 306-09-8933	5a AGE—Last Birthday (Year) 91	5b UNDER 1 YEAR Months: Days:	6 DATE OF BIRTH (Mo., Day, Year) Sept. 12, 1899	7 BIRTHPLACE (City and State or Foreign Country) Austurias, Spain
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> D.O.A. OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) Fountainview Place		9c CITY, TOWN, OR LOCATION OF DEATH Portage	9d COUNTY OF DEATH Porter	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Juanita Davalos	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Provider		12b KIND OF BUSINESS/INDUSTRY Sheet & Tin Mill U.S. Steel
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 541 South Hancock St.	
13e ZIP CODE 46403	13f INSIDE CITY LIMITS? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Spanish	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (13 or 9+)		18 FATHER'S NAME (First, Middle, Last) Jose Lopez		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Emilia Pardo		20a INFORMANT'S NAME (Type/Print) Juanita Lopez		
20b MAIN ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 South Hancock St., Gary, IN 46403		20c Relationship Wife		
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 (If other than place of death, specify other place) December 7, 1990 Chapel Lawn Memorial Garden		21c LOCATION—City or Town, State Schererville, IN
22a EMBALMER'S NAME Henry Blake		22b EMBALMER'S LICENSE NO. FD01019406	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert M. Fisher</i>		24b LICENSE NUMBER (of Licensee) FD010126724	24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Lach Funeral Home, 61-21 Miller Ave Gary, IN 46403 FH83002526	
25 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) Cardiac arrhythmia		25a APPROXIMATE INTERVAL BETWEEN CHEST AND DEATH DEC 7 1990		
b. CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DUE TO (OR AS A CONSEQUENCE OF)		25b APPROXIMATE INTERVAL BETWEEN CHEST AND DEATH		
c. OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not previously stated in Part I DUE TO (OR AS A CONSEQUENCE OF)		25c APPROXIMATE INTERVAL BETWEEN CHEST AND DEATH		
PART II: Other significant conditions—Conditions contributing to death but not previously stated in Part I		26 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		
27a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, 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.		28 AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		
29 SIGNATURE AND TITLE OF CERTIFIER <i>R. L. Barton MD</i>		29a MEDICAL LICENSE NO. 17667 Ind.	29b DATE SIGNED (Month, Day, Year) 12-5-90	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) R. L. Barton, 6101 Miller Ave, Gary, IN 46403				
31 HEALTH OFFICER'S SIGNATURE <i>Robert M. Fisher MD</i>		32 DATE FILED (Month, Day, Year) December 6, 1990		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <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)		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

Reg'd 41-53-3 Dist. Attorney 4.4 Bl. 2



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