INDIANA STATE BOARD OF HEALTH

Local No. 0509-92 — CERTIFICATE OF DEATH — State No. .....

92013423

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
PATRICIA A. COPE	FEMALE	6:05 A.M	MARCH 1, 1992

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 (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
311-12-3902	70			MARCH 16, 1921	JOHNSTOWN, PENNSYLVANIA

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
BROADWAY METHODIST HOSPITAL	MERRILLVILLE	LAKE

10 MARITAL STATUS (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	KENNETH L. COPE	CLERK	GARY PUBLIC LIBRARY

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GARY	6417 ASH AVENUE

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46403	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	XX No ☐ Yes	WHITE	12	

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
PHILIP R. PRICE	CLARA B. SHERRICK

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
KENNETH L. COPE	6417 ASH AVENUE, GARY, INDIANA 46403	HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of Cemetery Crematory or other place)	21c LOCATION—City or Town State
☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	MARCH 3, 1992 CALVARY CREMATORY	PORTAGE, INDIANA 46368

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
N/A	N/A	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
David C. Mayer	FDO 1012048	FH 83005613 REES FUNERAL HOME, OLSON CHAPEL 5341 CENTRAL AVE., PORTAGE, IN. 46368

CAUSE OF DEATH

26. PART I Enter the diseases 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

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Respiratory failure	10-15 min.
DUE TO (OR AS A CONSEQUENCE OF) b	Severe emphysema	2-5 yrs
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) c	Right lung cancer	6 mos
d		

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	N/A

CERTIFIER

29a CERTIFIER (Check only one)
- ☒ CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time date and place and due to the cause(s) as stated
- ☐ 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
- ☐ 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
[signature] MD	01029166	3/3/92

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

HAKAM SAFADI, M.D., 8695 CONNECTICUT, MERRILLVILLE, INDIANA 46410

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Alexander S. Williams, M.D	MAR 4 1992

CORONER 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 ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	Auditor Lake County

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian etc
	00222600

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Rees Funeral Home 600 E Ridge Rd Hobart X6342

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