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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0346-92 State No. ....

7 Reg 2 Vit 9 Total

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ROBERT C. PAPKA
2. SEX: Male
3a. TIME OF DEATH: 2:15P M
3b. DATE OF DEATH (Month, Day, Yr): February 11, 1992
4. SOCIAL SECURITY NUMBER: 314-24-1039
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): MAR 13, 1928
7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1948
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): JUANITA L. McBRIDE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): BAR OWNER
12b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOYED
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 127 FRASER LANE
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN PAPKA
19. MOTHER'S NAME (First, Middle, Maiden Surname): ELNA HAZELGREEN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JUANITA L. PAPKA
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 127 FRASER LANE, HOBART, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEB 14, 1992 CALVARY CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FDO1004194
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James G. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Carcinoma Lung with Metastatic Brain disease — Approximate Interval Between Onset and Death: 2 years
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. FEB 13 1992 APR 3 1992 LAKE COUNTY HEALTH COMMISSIONER (signature)

FILED

CERTIFIER

29a. CERTIFIER (Check only one): ☒ CERTIFYING PHYSICIAN To the [illegible] 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: K. P. Sarma, MD
29c. MEDICAL LICENSE NO.: 0127669
29d. DATE SIGNED (Month, Day, Year): 2/12/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): K.P. SARMA MD, 300 WEST 61ST AVENUE, HOBART, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): Feb. 13, 1992

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

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17-9-12-9 N. 50 ft of S. 1025 ft of E. 165 ft of 3rd of W. 2 SE SW. S. 38 T. 36 R. 7