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15-18-92

Helen Lipton

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0695-94

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

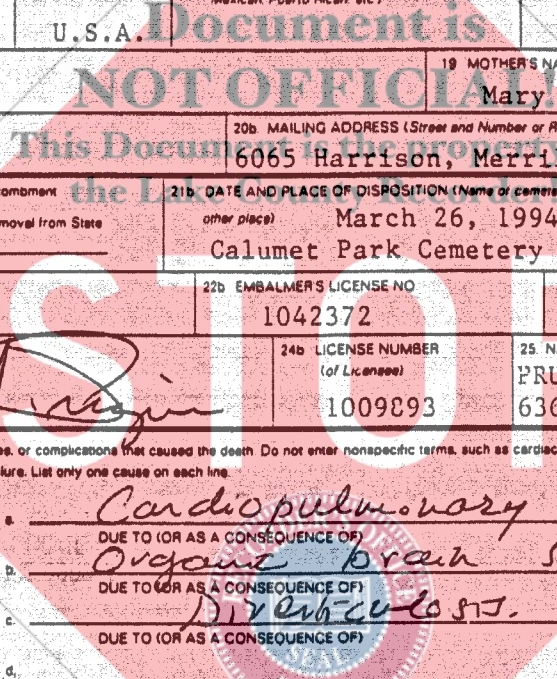
PARENTS

INFORMANT

DISPOSITION

W. 165.5 FT of S. 300' of N. 15A. of W. 19A. of SW. SE. of E. 19 FT S. 4 T. 35 R. 8. 883AC

1. DECEASED—NAME (First, Middle, Last) MATTHEW C. LIPTON		2. SEX Male	3a. TIME OF DEATH 12:25 AM	3b. DATE OF DEATH (Month, Day, Yr) March 23, 1994	
4. *SOCIAL SECURITY NUMBER 312-09-9472	5a. AGE—Last Birthday (Years) 78	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) October 31, 1915	
7. BIRTHPLACE (City and State or Foreign Country) Bruceville, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a. PLACE OF DEATH (Check only one—See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) Methodist Hospital - Southlake Campus		9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Helen Shipley	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor	12b. KIND OF BUSINESS/INDUSTRY Inland Steel		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Merrillville	13d. STREET AND NUMBER 6065 Harrison Street		
13e. ZIP CODE 46410	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 checked="" type="checkbox"/> No <input type="checkbox"/> 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) 2 College (1-4 or 5+) 2		18. FATHER'S NAME (First, Middle, Last) Martin Lipton			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Kopsho			20a. INFORMANT'S NAME (Type/Print) Helen Lipton		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6065 Harrison, Merrillville, IN 46410		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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 (Name of cemetery, crematory, or other place) March 26, 1994 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, Indiana	
22a. EMBALMER'S NAME Charles W. Wells		22b. EMBALMER'S LICENSE NO. 1042372	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas A. Pruzin</i>		24b. LICENSE NUMBER (of Licensee) 1009893	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410		
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. Cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF) b. Organic brain syndrome DUE TO (OR AS A CONSEQUENCE OF) c. DIV ERG CULOSIS DUE TO (OR AS A CONSEQUENCE OF) 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) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	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 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.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alexandra J. Shah</i>		29c. MEDICAL LICENSE NO. 01032180	29d. DATE SIGNED (Month, Day, Year) 3/23/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (UIM 26) (Type/Print) Surendra J. Shah, MD 5825 Broadway Suite A Merrillville IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>Alexandra J. Shah, MD</i> DATE FILED (Month, Day, Year) March 24, 1994					
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.	34d. DESCRIBE HOW INJURY OCCURRED 01890	
34c. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) MAR 31 1994		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes, no) If yes, specify driver, passenger, pedestrian, etc. <i>Anna N. Antox</i> AUDITOR LAKE COUNTY			



RECORDED
16. IN TO 6
APPROPRIATE
Interval Between
One and One and a Half
HOURS