(6)

Withdrawn 7-Carroll

Local No. 1 305-88

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: FIRST MILTON; MIDDLE NICHOLAS; LAST DOFFIN
2. SEX: Male
3. DATE OF DEATH (Month Day Year): February 12, 1988
4. SOCIAL SECURITY NUMBER: 314-24-1674
5a. AGE—Last Birthday (Years): 62
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month Day Year): Aug. 12, 1925
7. BIRTHPLACE (City and State or Foreign Country): Lotteville, Indiana
8. YEAR LAST SERVED IN U.S. ARMED FORCES: Yes 1946
9a. PLACE OF DEATH: HOSPITAL [X] Inpatient; OTHER
9b. FACILITY NAME (If not institution give street and number): St Anthony Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Eileen Stofa
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Dispatcher
12b. KIND OF BUSINESS/INDUSTRY: Telephone Industry
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lowell
13d. STREET AND NUMBER: 249 Island Drive
13e. INSIDE CITY LIMITS? (Yes or no): No
13f. FARM: NO
13g. ZIP CODE: 46356
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.): No [ ] Yes [X] Specify: X
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First Middle Last): Henry Doffin
18. MOTHER'S NAME (First Middle Maiden Surname): Amelia Krieter

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Eileen Doffin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 249 Island Drive Lowell, Indiana 46356
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Removal from State [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 16, 1988 Lowell Cemetery
20c. LOCATION—City or Town, State: Lowell, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: Gerald J Geisen
21b. LICENSE NUMBER (If licensed): FDE1041740
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home Ind. FDH3007762 7905 Broadway Merrillville, In 46410

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: R S Drasga
23b. LICENSE NUMBER:
23c. DATE SIGNED (Month Day Year):

24. TIME OF DEATH: 8:51 P.M.
25. DATE PRONOUNCED DEAD (Month Day Year): February 12, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): 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. Do not abbreviate. Do not enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Cardiac arrest due to (or as a consequence of):

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

due to (or as a consequence of):

Approximate Interval Between Onset and Death: 10 min

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

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

CERTIFIER

SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)

[ ] 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

[X] 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: R S Drasga
29c. LICENSE NUMBER: 01031484
29d. DATE SIGNED (Month Day Year): 2-15-88

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Ray S. Drasga, 8127 Merrillville Road, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month Day Year): 2-16-87

CORONER OR MEDICAL EXAMINER 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):

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