Tonjaleya Hopkins
1355 Ralston St
Gary, IN. 46406

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

No 0303

State No 95

Torres

/PRINT IN PERMANENT INK

1 DECEDENT—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Year)	
Birdia M. Hopkins		Female	3:00p.m.	April 7,1991	
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 (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
428-40-8059	68			October 9,1922	Mississippi
8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing home ☐ Other (Specify) ☒ Residence			
No	N/A				
9a FACILITY NAME (If not institution, give street and number)		9c CITY, TOWN, OR LOCATION OF DEATH		9d COUNTY OF DEATH	
2172 Baker St.		Gary		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	
Widowed	None	Packing Inspector		Continental Can	
13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION		13d STREET AND NUMBER	
Indiana	Lake	Gary		2172 Baker Street	
13e ZIP CODE	13f INSIDE CITY LIMITS? ☐ No ☒ Yes	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (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+)
46406	13g ON A FARM? ☒ No ☐ Yes	USA		Black	2 Years
18 FATHER'S NAME (First, Middle, Last)		19 MOTHER'S NAME (First, Middle, Maiden surname)			
Tobe Harris		Roberta Holmes			
20a INFORMANT'S NAME (Type/Print)		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		20c Relationship	
Tonjaleya Jones		1355 Ralston St. Gary, IN. 46406		Daughter	
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) April 13,1991 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, IN.	
22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes			
Patrician Owens	08700298				
24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME			
Patrician Owens	08700298	Guy & Allen Funeral Directors, Inc. 2959 W. 11th Ave. Gary, IN. 46404			

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. Enter only one cause on each line. Approximate interval between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Metastatic Small Cell Cancer — Unknown — 12 Mos.
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 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 FOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	

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)
Barbara L. Fuller, M.D.	01034701	4/15/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Barbara L. Fuller, M.D. 9229 Broadway Gary, IN 46409

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) APR 18 1991

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			NOV	

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, [illegible] passenger, pedestrian, etc.

000421

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

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