* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Joan M. Hodor
7115 Woodlawn
Hammond, In. 46324

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 245375

State No. 91

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Stanley J. Hodor
2 SEX	Male
3a TIME OF DEATH	4:09 PM
3b DATE OF DEATH (Month Day Yr)	October 28, 1995
4 *SOCIAL SECURITY NUMBER	315-09-5784
5a AGE—Last Birthday (Years)	77
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo. Day Yr)	May 7, 1918
7 BIRTHPLACE (City and State or Foreign Country)	East Chicago, Indiana
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	1946
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	Methodist Hospital-South Lake
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)	Joan Kucek
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Electrical Engineer
12b KIND OF BUSINESS/INDUSTRY	Inland Steel Company
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	7115 Woodlawn Avenue
13e ZIP CODE	46324
13f INSIDE CITY LIMITS	[ ] No [X] Yes
13g ON A FARM?	[X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12th
College (1-4 or 5+)	---

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	John S. Hodor
19 MOTHER'S NAME (First Middle Maiden Surname)	Julia Bradtke

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Joan Hodor
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7115 Woodlawn Avenue, Hammond, In. 46324
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	November 1, 1995 St. John Cemetery
21c LOCATION—City or Town, State	Hammond, Indiana
22a EMBALMER'S NAME	Dean G. Wagner
22b EMBALMER'S LICENSE NO.	8800057
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Dean G. Wagner (signature)
24b LICENSE NUMBER (of Licensee)	8800057
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, Ind. 46324

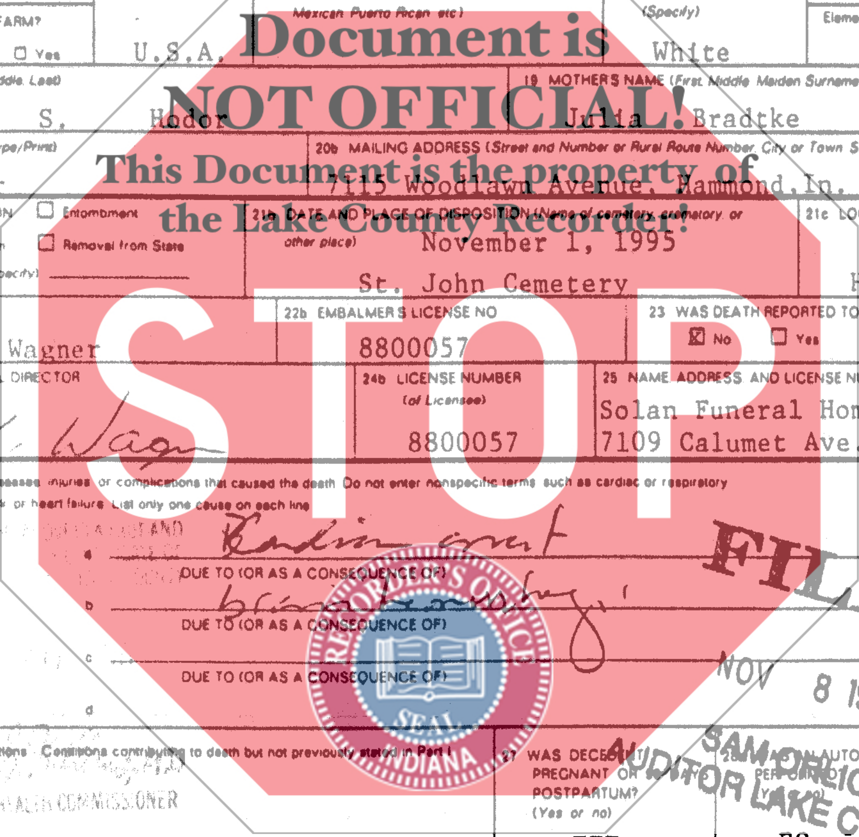
CAUSE OF DEATH

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Cardiac arrest	
DUE TO (OR AS A CONSEQUENCE OF) b	[illegible]	
DUE TO (OR AS A CONSEQUENCE OF) c		
DUE TO (OR AS A CONSEQUENCE OF) d		

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

Field	Entry
27 WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no)	---
28a WAS AUTOPSY PERFORMED?	no
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	


Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP

FILED NOV 8 1995 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 NOV -8 AM 10:31 MARGARET ... RECORDER

LAKE COUNTY HEALTH COMMISSIONER

95068945

CERTIFIER

29a CERTIFIER (Check only one)

[X] 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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	M. Hytham Rifai (signature)
29c MEDICAL LICENSE NO.	01035906
29d DATE SIGNED (Month Day Year)	10-30-95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	M. Hytham Rifai, M.D. 103 E 89th Ave Merrillville, IN 46410

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature], M.D.
32 DATE FILED (Month Day Year)	October 30, 1995

Field	Entry
33 MANNER OF DEATH	[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
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.	

000518

Kuf # 32-101-11

CS 90 SK

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1