No. [illegible]0303

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

/PRINT IN /IANENT CK INK

1. DECEASED—NAME (First, Middle, Last): Birdia M. Hopkins
2. SEX: Female
3a. TIME OF DEATH: 3:00p.m.
3b. DATE OF DEATH (Month, Day, Yr.): April 7,1991
4. SOCIAL SECURITY NUMBER: 428-40-8059
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): October 9,1922
7. BIRTHPLACE (City and State or Foreign Country): Mississippi
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one; See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing home ☐ Other (Specify) ☒ Residence

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9b. FACILITY NAME (If not institution, give street and number): 2172 Baker St.
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Packing Inspector
12b. KIND OF BUSINESS/INDUSTRY: Continental Can
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 2172 Baker Street
13e. ZIP CODE: 46406
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): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 2 Years

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18. FATHER'S NAME (First, Middle, Last): Tobe Harris
19. MOTHER'S NAME (First, Middle, Maiden Surname): Roberta Holmes

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20a. INFORMANT'S NAME (Type/Print): Tonjaleya Jones
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1355 Ralston St. Gary,IN. 46406
20c. Relationship: Daughter
21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 13,1991 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart,IN.

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22a. EMBALMER'S NAME: Patrician Owens
22b. EMBALMER'S LICENSE NO.: 08700298
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W.11th Ave. Gary,IN 46404 8300778

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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. Metastatic Small Cell Cancer, Primary Unknown — Approximate Interval Between Onset and Death: 14 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 resulting in the underlying cause given 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):
☒ 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.

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29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara L Fuller, M.D.
29c. MEDICAL LICENSE NO.: 01034701
29d. DATE SIGNED (Month, Day, Year): 4/15/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Barbara L. Fuller, M.D. 3229 Broadway Gary, In 46409

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31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): APR. 18 1991

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.

ONER ONLY

FILED
NOV 30 1995
SAM ORLICH
AUDITOR LAKE COUNTY
001801

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
91 [illegible] 2:59
RECORDER

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