* 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.

Local No. 2111-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
LEROY C. HOSTETTER	MALE	12:30 AM	SEPTEMBER 19, 1995

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 (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
306-09-4003	84			MAY 14, 1911	SHARON, PENNSYLVANIA

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
YES-US NAVY	1946	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARY MEDICAL CENTER	HOBART	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	STEELWORKER	US STEEL-GARY WORKS

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GARY	4790 KENTUCKY STREET

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY	15 WAS DECEDENT OF HISPANIC ORIGIN?	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 +)
46408	☐ No ☒ Yes	☒ No ☐ Yes	U.S.	☐ No ☐ Yes (If yes specify Cuban Puerto Rican etc)	WHITE	8	0

PARENTS

18 FATHER'S NAME First Middle Last	19 MOTHER'S NAME (First Middle Maiden Surname)
CHARLES HOSTETTER	STELLA

INFORMANT

20a INFORMANT'S NAME (Type Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
CHARLES E. HOSTETTER	9[illegible] MALLARD DR., VALPARAISO, IN. 46383	SON

DISPOSITION

21a METHOD OF DISPOSITION	21b PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
☒ Burial ☐ Cremation ☐ Removal from state ☐ Donation ☐ Other (Specify)	SEPTEMBER 22, 1995 CALUMET PARK CEMETERY	MERRILLVILLE, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
RUSSELL A. KRAFT, JR.	29300105	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James E. Burns	1009461	BURNS FUNERAL HOME FDH#3002380 701 E. 7TH STREET, HOBART, IN 46342

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF)
b. Arteriosclerotic Heart Disease

Conditions if any which gave rise to the immediate cause stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
c.

DUE TO (OR AS A CONSEQUENCE OF)
d.

Approximate Interval Between Onset and Death: OCT TO 1995

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 PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	NO

CERTIFIER

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)
Jerold N. Chip	19735	9/21/95

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
JEROLD N. CHIP, M. D., 7863 BROADWAY, MERRILLVILLE, INDIANA 46410 (769-3678)

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
[signature] M.D.	September 21, 1995

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				

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

001270

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

43-464-27

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 MAY 29 AM 9:25 RECORDER

THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

LAKE COUNTY HEALTH COMMISSIONER