12 Reg.
2 Ved
14 Total

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 3125-91 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): FRANCIS A. 'AL' LEPP	2. SEX: Male	3a. TIME OF DEATH: 10:44P M	3b. DATE OF DEATH (Month, Day, Yr.): December 6, 1991
4. SOCIAL SECURITY NUMBER: 317-20-6547	5a. AGE—Last Birthday (Years): 65	5b. UNDER 1 YEAR (Months / Days) / 5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo. Day, Yr): APR 23, 1926
7. BIRTHPLACE (City and State or Foreign Country): GARY, 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): ST. MARY MEDICAL CENTER	9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART	9d. COUNTY OF DEATH: LAKE	
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): MARGARET E. RADDACH	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): INDUSTRIAL ENGINEER	12b. KIND OF BUSINESS/INDUSTRY: US STEEL TUBEWORKS
13a. RESIDENCE—STATE: INDIANA	13b. COUNTY: LAKE	13c. CITY, TOWN, OR LOCATION: HOBART	13d. STREET AND NUMBER: 243 N. CALIFORNIA ST.
13e. ZIP CODE: 46342	13f. INSIDE CITY LIMITS: [ ] No [X] Yes; 13g. ON A FARM? [X] No [ ] Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE	17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 4		

PARENTS

18. FATHER'S NAME (First, Middle, Last): LOUIS LEPP	19. MOTHER'S NAME (First, Middle, Maiden Surname): EMILIA ZUBEK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARGARET E. LEPP	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 243 N. CALIFORNIA STREET, HOBART, IN 46342	20c. Relationship: Wife

DISPOSITION

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): DEC 9, 1991 CALUMET PARK CEMETERY	21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON	22b. EMBALMER'S LICENSE NO.: FDO1004194	23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause	24b. LICENSE NUMBER (of Licensee): FDO1006463	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, 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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Massive Pulmonary Hemorrhage — 12/5/91

Conditions, if any, which give rise to the immediate cause, stating the underlying cause last:

b. DUE TO (OR AS A CONSEQUENCE OF): Subarachnoid Hemorrhage — 12/6/91

c. DUE TO (OR AS A CONSEQUENCE OF): Septicemia

d.

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

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter R. Sala, M.D.	29c. MEDICAL LICENSE NO.: 15348	29d. DATE SIGNED (Month, Day, Year): 12/11/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): WALTER R. SALA MD, 5490 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D. — 32. DATE FILED (Month, Day, Year):

CORONER 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)		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

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

DEC 11 1991

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
SEP 5 1996
SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 SEP 5 PM 1:5
MARGARET ... RECORDER

96059363

000289

Reg# 17-83-31

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