

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

Paula Minard
7420 Carolina Ave.
Hamd IN 46323

Local No. 2465-97

CERTIFICATE OF DEATH

State No. 256532

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) ROBERT HOPKINS		2 SEX MALE	3a TIME OF DEATH 8:33 A.M.	3b DATE OF DEATH (Month Day, Yr) NOVEMBER 25, 1997
4 SOCIAL SECURITY NUMBER 336-20-8789	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) June 17, 1929
7 BIRTHPLACE (City and State or Foreign Country) Steger, Illinois	8a WAS DECEDENT A U.S. VETERAN? Yes			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1952		8c PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9b CITY, TOWN OR LOCATION OF DEATH MUNSTER	9c COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) Never Married	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) Roller	12b KIND OF BUSINESS/INDUSTRY Steel	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Dyer	13d STREET AND NUMBER 14109 Jay Street	
13e ZIP CODE 46311	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) USA
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (11-4 or 5+)		18 FATHER'S NAME (First Middle Last) Carl Hopkins		
19 MOTHER'S NAME (First Middle Maiden Surname) Margaret Crooks		20a INFORMANT'S NAME (Type/Print) Kathryn E. Kaiser		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14109 Jay Street; Dyer, IN 46311		20c Relationship Sister		
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 29, 1997 Calumet Park Cemetery		21c LOCATION—City, Town, State Merrillville, Indiana
22a EMBALMER'S NAME Henry Blake		22b EMBALMER'S LICENSE NO. FDO1019406	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Lawrence Miller</i>		24b LICENSE NUMBER (of Licensee) FDO1006015	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Home 8001504 1920 Hart St.; Dyer, Indiana 46311	
26 PART I Enter the disease, injuries or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. Use only one term on each line. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.				
IMMEDIATE CAUSE (Enter on line with the lake county health dept. resulting in death) acute myocardial infarction				
DUE TO (OR AS A CONSEQUENCE OF) Coronary artery disease				
Conditions if any which give rise to the immediate cause, stating the underlying cause last NOV 26 1997				
DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions—Conditions contributing to death but not previously stated in Part I massive upper gastro-intestinal bleeding				
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) No
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Alexander S. Hillman MD</i>		29c MEDICAL LICENSE NO. 01031576	29d DATE SIGNED (Month, Day, Year) NOVEMBER 26, 1997	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) WON-SHICK LOH, M.D. 9134 COLUMBIA AVENUE MUNSTER, INDIANA 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Hillman MD</i>				32 DATE FILED (Month, Day, Year) November 26, 1997
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED FILED		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) D.C. 02 1997		
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. 000185		34i		

un. # 08
Key # 11-9-86
PT N's NW S.19 T.35 R.9 O.345AC

FILED
D.C. 02 1997
SAM ORLICH
AUDITOR LAKE COUNTY