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PORTER COUNTY

CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

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)
FRITZ W. SEIPELT	Male	12:30 PM	May 17, 1998

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)
304-36-5341	70			March 20, 1928	Germany

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	8e PLACE OF DEATH (Check only one See instructions)
Yes	1955	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☒ Other (Specify) ☐ Residence: Hospice Center

8b FACILITY NAME (If not institution, give street and number)	8c CITY, TOWN OR LOCATION OF DEATH	8d COUNTY OF DEATH
VNA Mary Bartz Hospice Center	Valparaiso	Porter

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
Married	Rose Thoiss	Expeditor	U.S. Steel

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Merrillville	5730 Pennsylvania Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	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 +)
46410	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White		2

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Franz Seipelt	Emma Nixdorf

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
Rose Seipelt	5730 Pennsylvania St, Merrillville, IN 46410	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 20, 1998 Calumet Park Cemetery	Merrillville, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
David Patton	29600056	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1009893	PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410

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. Cardio Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Hepatic Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF)	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF)	
	d.	

FILED JUN 08 [redacted]

SAM CRUCH
AUDITOR LAKE CO.

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)	28 IF NOT, WAS AUTOPSY PERFORMED? (Yes or no)	29 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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)
I. Zabaneh M.D.	01033620	May 19, 1998

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
I. Zabaneh, M.D., 6111 Harrison Street, Merrillville, IN 46410 (219) 980-4242

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Gary A. Babcock MD	May 20, 1998

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)
	9.00 cm

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc
	000702 Bgh

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