* ATTENTION ESTATE: Disclosure of the SS# No need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 2557-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Key# 24-89-5

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): Edward E. Troy
2. SEX: Male
3a. TIME OF DEATH: 11:50PM
3b. DATE OF DEATH (Month Day Yr): August 10, 1996
4. SOCIAL SECURITY NUMBER: 311-26-1877
5a. AGE - Last Birthday (Years): 66
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): Feb 28, 1930
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St Anthony Medical Center
9c. CITY TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Betty Glade
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Sheet Metal Maintainence
12b. KIND OF BUSINESS INDUSTRY: Automobile Manufacturing
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Cedar Lake
13d. STREET AND NUMBER: 14343 Truman St.
13e. ZIP CODE: 46303
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): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Paul William Troy
19. MOTHER'S NAME (First, Middle, Maiden Surname): Isabelle McKay

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Betty Troy
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14343 Truman St., Cedar Lake, IN 46303
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Aug 14, 1996 Holy Name
21c. LOCATION - City or Town State: Cedar Lake, IN
22a. EMBALMER'S NAME: Fred T. Oparka
22b. EMBALMER'S LICENSE NO.: FD01016076
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Fred Oparka
24b. LICENSE NUMBER (of Licensee): FD01016076
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83000825 Eller Brady Funeral Home Inc. 8510 Lakeshore dr., Cedar Lake, IN 46303

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. Alveol Emphysema
Conditions if any which gave rise to the immediate cause, stating the underlying cause last: b. DUE TO (OR AS A CONSEQUENCE OF); c. DUE TO (OR AS A CONSEQUENCE OF); d.

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): 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

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: [signature] MD
29c. MEDICAL LICENSE NO: 01030518
29d. DATE SIGNED (Month Day Year): 8-14-96
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Sompop, 8315 Virginia St., Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature], MD
32. DATE FILED (Month Day Year): August 14, 1996

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): 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.: No

000569

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 98 SEP -9 AM

SEP 8 1998

SAM ORLICH AUDITOR LAKE COUNTY

TICOR TITLE INSURANCE Crown Point, Indiana

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Return to: NBD - Merr.