10D-C

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. 014-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
DORIS H. SPROUT	FEMALE	6:06 A M	JANUARY 17, 1999

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)
399-01-3875	82	99081604		MARCH 18, 1916	MILWAUKEE, WISCONSIN

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions.)
NO	--	HOSPITAL XX 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. ANTHONY MEDICAL CENTER	CROWN POINT	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	FOOD SERVICE DIRECTOR	CROWN POINT SCHOOL SYSTEM

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	CROWN POINT	9915 MERRILLVILLE ROAD

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)	
46307	☐ No XX Yes	XX No ☐ Yes	USA	XX No ☐ Yes	WHITE	Elementary/Secondary (0-12)	College (1-4 or 5 +) 4

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
RAY E. COERPER	LILLIAN KUNKEL

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
CRAIG N. SPROUT	3887 SUGAR CREEK DR., MERIDIAN, IDAHO 83642	SON

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
XX Entombment ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	JANUARY 20, 1999 WISCONSIN MEMORIAL PARK	BROOKFIELD, WISCONSIN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
DAVID PATTON	29600056	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
	1009893	PRUZIN & LITTLE FUNERAL SERVICE #83001261 811 E. FRANCISCAN DR, CROWN POINT, IN 46307

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.	Pneumonia	1-2 Days
Conditions if any, which gave rise to the immediate cause stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF) b.	JAN 19 1999 OCT 04 1999	
DUE TO (OR AS A CONSEQUENCE OF) c.		
d.		

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

malnutrition
Acute renal failure
congestive heart Failure
thrombocytopenia

27 IF FEMALE, 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	--

CERTIFIER

29a CERTIFIER (Check only one)

XX 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)
Theodore Brogan MD	#01048142	1/19/99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
Theodore Brogan M.D., 1121 S. Indiana Ave., Crown Point, IN 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE — Alexander S. Hilkevitch MD

32 DATE FILED (Month, Day, Year) January 19, 1999

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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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)
	000113 9.00 E.P. T1

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

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

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STOP
FILED
PETER BENJAMIN
LAKE COUNTY AUDITOR

TICOR TITLE INSURANCE
Crown Point, Indiana
93-7-5
K# 93-6458