

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH STATE OF INDIANA

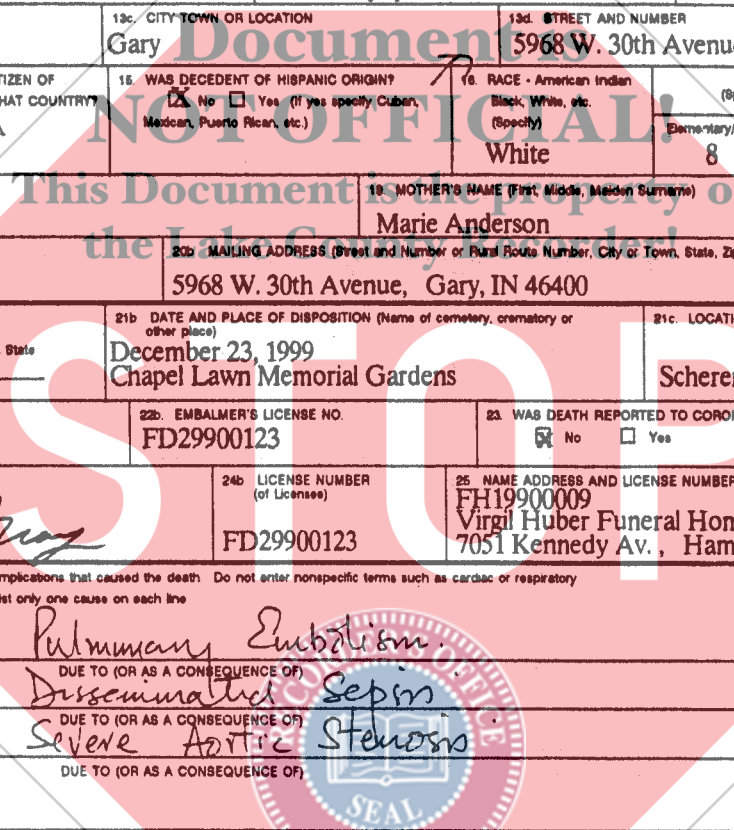
Local No. 2940-99

LAKE COUNTY

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

385376
TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED-NAME (First Middle Last) Paul Henry Shropshire		2. SEX Male	3a. TIME OF DEATH 2:45AM	3b. DATE OF DEATH (Month Day Yr) December 21, 1999
4. SOCIAL SECURITY NUMBER 412-34-0918	5a. AGE (Years) 72	5b. UNDER 1 YEAR Months Days 2 000 023912	5c. UNDER 1 DAY Hours Minutes 2000 1111	5d. DATE OF BIRTH (Mo Day Yr) 6. BIRTHPLACE (City and State or Foreign Country) May 25, 1927 Andersonville, TN
7a. WAS DECEDENT A U.S. VETERAN? No	7b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	8. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) Community Hospital		9b. CITY TOWN OR LOCATION OF DEATH Munster	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	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) Mobile Equipment Mechanic	12b. KIND OF BUSINESS INDUSTRY Manufacturing	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Gary	13d. STREET AND NUMBER 5968 W. 30th Avenue	
13e. ZIP CODE 46406	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE - American Indian, Black, White, etc. (Specify) White
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	17. DECEDENT'S EDUCATION (Specify only highest grade completed) 8		17. DECEDENT'S EDUCATION (Specify only highest grade completed) 8	
18. FATHER'S NAME (First, Middle, Last) Walter Shropshire		19. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Anderson		
20a. INFORMANT'S NAME (Type/Print) Paula Sue Franz		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5968 W. 30th Avenue, Gary, IN 46400		20c. Relationship Daughter
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input 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) December 23, 1999 Chapel Lawn Memorial Gardens		21c. LOCATION - City or Town State Schererville, Indiana
22a. EMBALMER'S NAME Henry A. Gray		22b. EMBALMER'S LICENSE NO. FD29900123		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Henry A. Gray</i>		24b. LICENSE NUMBER (of License) FD29900123	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323	
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) Pulmonary Embolism				
DUE TO (OR AS A CONSEQUENCE OF) Disseminated Sepsis				
DUE TO (OR AS A CONSEQUENCE OF) Severe Aortic Stenosis				
DUE TO (OR AS A CONSEQUENCE OF)				
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	
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>A. Siddiqi M.D.</i>		29c. MEDICAL LICENSE NO. 01047964
29d. DATE SIGNED (Month Day Year) 12-23-99		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Alam Siddiqi, 10448 S. Pulaski, Oak Lawn, IL 60453		
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>		32. DATE FILED (Month Day Year) December 28, 1999		
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) APR 07 2000	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) PETER BENJAMIN LAKE COUNTY AUDITOR		34e. LOCATION (Street and Number or Rural Route Number, City or Town State) DEC 28 1999 900 E.P.		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian LAKE COUNTY HEALTH COMMISSIONER		



FILED

Unit #4
Key # 49-488-5
T.H. Wein Black Oak Sub Lot #5 Block 2