27-85-28

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1743-93 — CERTIFICATE OF DEATH — State No.

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

2000 029210
2000 MAY -1 AM 11:05
MORRIS W. CARTER
RECORDER
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1 Deceased—Name (First, Middle, Last)	JOSEPHINE POPOVICH
2 Sex	FEMALE
3a Time of Death	7:30 P.M.
3b Date of Death (Month Day Yr)	JULY 11, 1993
4 Social Security Number	359-10-1243
5a Age—Last Birthday (Years)	75
5b Under 1 Year (Months, Days)	
5c Under 1 Day (Hours, Minutes)	
6 Date of Birth (Mo Day Yr)	Jul 28, 1917
7 Birthplace (City and State or Foreign Country)	East Chicago, Indiana
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b Facility Name (If not institution give street and number)	THE COMMUNITY HOSPITAL
9c City, Town or Location of Death	MUNSTER
9d County of Death	LAKE
10 Marital Status (Specify)	Married
11 Surviving Spouse (If wife give maiden name)	John Popovich
12a Decedent's Usual Occupation	Home Maker
12b Kind of Business/Industry	Own Home
13a Residence—State	Indiana
13b County	Lake
13c City, Town or Location	Highland
13d Street and Number	3131 Highway
13e Zip Code	46322
13f Inside City Limits	[ ] No [X] Yes
13g On a Farm?	[X] No [ ] Yes
14 Citizen of What Country?	U.S.A.
15 Was Decedent of Hispanic Origin?	[X] No [ ] Yes
16 Race	White
17 Decedent's Education (Elementary/Secondary 0-12; College 1-4 or 5+)	11

PARENTS

Field	Value
18 Father's Name (First, Middle, Last)	Consantine Port
19 Mother's Name (First, Middle, Maiden Surname)	Stella Dzik

INFORMANT

Field	Value
20a Informant's Name (Type/Print)	John Popovich
20b Mailing Address	3131 Highway Highland, Indiana
20c Relationship	Husband

DISPOSITION

Field	Value
21a Method of Disposition	[X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b Date and Place of Disposition	July 14, 1993 Chapel Lawn Cemetery
21c Location—City or Town, State	Schererville, Indiana
22a Embalmer's Name	Ronald A. Reed
22b Embalmer's License No.	FDO 1001081
23 Was Death Reported to Coroner?	[X] No [ ] Yes
24a Signature of Funeral Director	[signature]
24b License Number (of Licensee)	FDO 1014511
25 Name, Address and License Number of Funeral Home	Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

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.

JUL 15 1993

	Cause	Approximate Interval Between Onset and Death
a. Immediate Cause (Final disease or condition resulting in death)	Cardio-respiratory arrest	20 min
b. Due to (or as a consequence of)	[illegible]	5 yrs
c. Due to (or as a consequence of)		
d.		

Conditions if any which gave rise to the immediate cause, stating the underlying cause last

[signature] MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
MAY 01 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Aortic Valve replacement, Coronary Artery bypass

Field	Value
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)	

CERTIFIER

29a Certifier (Check only one)
- [X] 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

Field	Value
29b Signature and Title of Certifier	[signature]
29c Medical License No.	26577
29d Date Signed (Month Day Year)	JULY 14, 1993

30 Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): DR. KWANG D. YOU, M. D. 931 FRAN LIN PARKWAY MUNSTER, INDIANA 46321

HEALTH OFFICER

Field	Value
31 Health Officer's Signature	[signature] MD
32 Date Filed (Month Day Year)	July 15, 1993

Field	Value
33 Manner of Death	[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a Date of Injury (Month Day Year)	
34b Time of Injury	
34c Injury at Work? (Yes or 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.	

9.00 E.P. CS 112

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