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

Local No. 201

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3 NI01000092

THIS CERTIFIES THE FOLLOWING IS A TRUE A COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

MAR 8 1999
Date Issued

Franklin D. Greenlee M.D.
Hammond Health Commissione

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)
MICHAEL F. KRUPA	Male	5:55PM	March 4, 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)
344-42-9455	45			March 1, 1954	Chicago, Illinois

8a. WAS DECEDENT A US VETERAN?	8b. YEAR LAST SERVED IN US ARMED FORCES	8c. PLACE OF DEATH (Check only one. See Instructions)
Yes	1992	HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

8d. FACILITY NAME (If not hospital/um, give street and number)	8e. CITY TOWN OR LOCATION OF DEATH	8f. COUNTY OF DEATH
St. Margaret Mercy Hospital	Hammond	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
Married	Florence O'Connor	Carpenter/Laborer	Construction

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	3810 Montgomery 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)	
46342	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Arthur Krupa	Carol Forst

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
Florence Krupa	3810 Montgomery Street, Hobart, IN 46342	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
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment	March 8, 1999 Calvary Crematory	Portage, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FD01006463	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FD01006463	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. Massive blunt force trauma	Unknown
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. 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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	Yes	Yes

CERTIFIER

29a. CERTIFIER (Check only one): DEPUTY

☐ 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)
	N/A	March 8, 1999

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Greenlee M.D.

32. DATE FILED (Month Day Year): March 8, 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 ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide	March 4, 1999	Unknown	Yes	Blunt Force Trauma

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)
office building	221 Clinton Street Hammond, Indiana

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.
March 4, 1999	

SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

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