

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1378-00

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

ALTH OFFICER

1 DECEASED—NAME (First Middle Last) Shirley M. Kapitan		2 SEX Female	3a TIME OF DEATH 2:45 A.M.	3b DATE OF DEATH (Month Day Yr) June 11, 2000
4 *SOCIAL SECURITY NUMBER 306-36-7600	5a AGE—Last Birthday (Years) 64	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) April 26, 1936
7 BIRTHPLACE (City and State or Foreign Country) Whiting, 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.) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence
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) Cornelius Kapitan	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker		12b KIND OF BUSINESS/INDUSTRY Own Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY/TOWN OR LOCATION Griffith		13d STREET AND NUMBER 1306 N. Arbogast
13e ZIP CODE 46319	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12		18 FATHER'S NAME (First Middle Last) Charles Coil		
19 MOTHER'S NAME (First Middle Maiden Surname) Hazel Stickley		20a INFORMANT'S NAME (Type/Print) Cornelius Kapitan		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 N. Arbogast, Griffith, IN 46319		20c Relationship Husband		
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) June 14, 2000 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Schererville, Indiana
22a EMBALMER'S NAME Dave R. Peterson		22b EMBALMER'S LICENSE NO. FD08601585		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ronald G. Reed</i>		24b LICENSE NUMBER (of Licensee) FD01001081		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home FH83007500 9039 Kleinman Rd. Highland, IN
26 PART I Enter the disease, 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 <i>intracerebral hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF) JUN 23 2000		
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b DUE TO (OR AS A CONSEQUENCE OF)		
		c PETER BENJAMIN LAKE COUNTY AUDITOR		
		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) 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) N/A
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>Michael J. ...</i>		29c MEDICAL LICENSE NO. 01023340		29d DATE SIGNED (Month Day Year) 6-12-2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print) M. Levin, MD 9003 Calumet Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>				32 DATE FILED (Month Day Year) June 12, 2000
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
		34d DESCRIBE HOW INJURY OCCURRED 21162		
		34a 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) 909 St. CS
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		