

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

4215 #

39-26-60

Local No. 1234-98

CERTIFICATE OF DEATH

State No.

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

260309
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Donald G. Hendricks				2. SEX Male		3a. TIME OF DEATH 7:50 A		3b. DATE OF DEATH (Month, Day, Yr.) May 27, 1998		
4. SOCIAL SECURITY NUMBER 307-38-1062		5a. AGE—Last Birthday (Years) 58		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) Jun. 27, 1939		
7a. WAS DECEDENT A U.S. VETERAN? YES		7b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1968		7. BIRTHPLACE (City and State or Foreign Country) Dunreith, Indiana						
9a. FACILITY NAME (If not institution, give street and number) The Community Hospital				9b. CITY, TOWN, OR LOCATION OF DEATH Munster			9c. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Loretta Collins		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) First Furnace Man			12b. KIND OF BUSINESS/INDUSTRY Steel Co.			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary (Calumet Township)			13d. STREET AND NUMBER 2447 W. 47th ave.			
13e. ZIP CODE 46408		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) Elementary/Secondary (0-12) College (1-4 or 5+) 12		15. FATHER'S NAME (First, Middle, Last) Herman Hendricks				19. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Nichols				
20a. INFORMANT'S NAME (Type/Print) Loretta Hendricks				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2447 W. 47th Ave. Gary, Indiana				20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) May 30, 1998 Calumet Park cemetery				21c. LOCATION—City or Town, State Merrillville, Indiana			
22a. EMBALMER'S NAME Edgar Gleim				22b. EMBALMER'S LICENSE NO. FDO 1016173		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James S. ...</i>				24b. LICENSE NUMBER (of Licenses) FDO 1010850		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500				
28. 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. PNEUMOCOCCAL SEPSIS b. MULTIPLE MYELOMA c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last JUL 06 1998									Approximate Interval Between Onset and Death	
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>Nardisa ...</i>						29c. MEDICAL LICENSE NO. 01029300		29d. DATE SIGNED (Month, Day, Year) 05.28.1998		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Nitin Sardesai 9307 Calumet Munster										
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. ...</i>								32. DATE FILED (Month, Day, Year) May 28 1998		
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. PLACE AND HOW INJURY OCCURRED JAN 25 2002		
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) PETER BENJAMIN LAKE COUNTY AUDITOR						
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

001652 9.4
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