* **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.

Local No. 303

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

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

APR 16, 2002 Date Issued — Franklin D. Gremuda M.D. Hammond Health Commissione

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JOSE M. HINOJOSA
2. SEX: MALE
3a. TIME OF DEATH: 7:50 P M
3b. DATE OF DEATH (Month, Day, Yr.): APRIL 13, 2002
4. *SOCIAL SECURITY NUMBER: 450-54-0297
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): OCTOBER 9,1936
7. BIRTHPLACE (City and State or Foreign Country): MAXWELL TEXAS
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1963
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1633-173rd PLACE
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MARY E. RUIZ
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: INLAND STEEL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 1633-173rd PLACE
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): MEXICAN
16. RACE—American Indian, Black, White, etc (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): SANTIAGO HINOJOSA
19. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES MENDEZ

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARY E. HINOJOSA
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1633-173rd PLACE, HAMMOND, INDIANA 46324
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 16, 2002 HERITAGE CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: NONE
22b. EMBALMER'S LICENSE NO.: n/a
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Dean L. Wagner
24b. LICENSE NUMBER (of Licensee): 8800057
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH83002893 7109 CALUMET AVE., HAMMOND, IN. 46324

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Metastatic Colon CA — Approximate Interval Between Onset and Death: 2 years
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR WITHIN 1 YEAR OF PREGNANCY? (Yes or no)	28. WAS AN AUTOPSY PERFORMED? (Yes or no)	28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
no	no	n/a

CERTIFIER

29a. CERTIFIER (Check only one):
☒ 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.: 01041056
29d. DATE SIGNED (Month, Day, Year): APRIL 15, 2002

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): G. Jano M.D. 7905 Calumet Ave., Munster, Indiana 46321 836-5800
31. HEALTH OFFICER'S SIGNATURE: Franklin D. Gremuda M.D.
32. DATE FILED (Month, Day, Year): April 16, 2002

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): 1901
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

9.00 CASH

SDH06-004 State Form 10110 (R5/1-99)