

* 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 CERTIFICATE OF DEATH

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

Local No. 97

State | Feb 8 2002 *Franklin D. Spradlin, M.D.*
Date Issued Hammond Health Commissioner

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

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Jill A. Johnsen		2. SEX Female	3a. TIME OF DEATH 3:40 AM	3b. DATE OF DEATH (Month, Day, Yr.) February 6, 2002	
4. *SOCIAL SECURITY NUMBER 310-62-4185	5a. AGE—Last Birthday (Years) 47	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo, Day, Yr.) Apr. 18, 1954	
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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) 6717 Huron Ave.		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) Raymond Johnsen	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Maintenance		12b. KIND OF BUSINESS/INDUSTRY Mall	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond	13d. STREET AND NUMBER 6717 Huron Ave.		
13e. ZIP CODE 46323	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) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____					
18. FATHER'S NAME (First, Middle, Last) Ernst Kraft			19. MOTHER'S NAME (First, Middle, Maiden Surname) Delores Stange		
20a. INFORMANT'S NAME (Type/Print) Raymond Johnsen		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6717 Huron Ave., Hammond, Indiana 46323		20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) February 8, 2002 Regional Cremation Service		21c. LOCATION—City or Town, State Munster, Indiana	
22a. EMBALMER'S NAME None		22b. EMBALMER'S LICENSE NO. N/A	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ronald A. Neal</i>		24b. LICENSE NUMBER (of Licensee) FDO 1001081	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Rd Highland, Indiana 46322 FH 19900008		
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. <i>Metastatic Melanoma</i> DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death <i>1 year</i>	
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)		
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) as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Franklin D. Spradlin, M.D.</i>			29c. MEDICAL LICENSE NO. 31660256	29d. DATE SIGNED (Month, Day, Year) 2-7-02	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) G. L. Lavo, M.D., 7905 CARMEL AVE, MUNSTER, IN, 46321					
31. HEALTH OFFICER'S SIGNATURE <i>Franklin D. Spradlin, M.D.</i>				32. DATE FILED (Month, Day, Year) February 8, 2002	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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
		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.			

