

* 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

State No.

Local No. 2495-95

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) WITTRUP MINNA		2 SEX FEMALE	3a TIME OF DEATH 12:25 P_M	3b DATE OF DEATH (Month, Day, Yr) NOVEMBER 1, 1995
4 *SOCIAL SECURITY NUMBER 304-58-9393	5a AGE—Last Birthday (Years) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) AUG. 15, 1932
7 BIRTHPLACE (City and State or Foreign Country) DENMARK	8a WAS DECEASENT 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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) METHODIST SOUTHLAKE CAMPUS		9c CITY, TOWN OR LOCATION OF DEATH MERRILLVILLE	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) JAKOB WITTRUP	12a DECEASENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) ART TEACHER		12b KIND OF BUSINESS/INDUSTRY GARY SCHOOL SYSTEM
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION CROWN POINT	13d STREET AND NUMBER 3464 HIGHLAND COURT	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEASENT 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 DECEASENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (11-4 or 5+) <input checked="" type="checkbox"/> 5 1/2		18 FATHER'S NAME (First, Middle, Last) KARB BROK		
19 MOTHER'S NAME (First, Middle, Maiden Surname) METTE BUUS		20a INFORMANT'S NAME (Type/Print) JAKOB WITTRUP		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3464 HIGHLAND CT., CROWN POINT, IN 46307		20c Relationship HUSBAND		
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) NOVEMBER 4, 1995 CHAPEL LAWN MEMORIAL GARDENS		21c LOCATION—City or Town, State SCHERERVILLE INDIANA
22a EMBALMER'S NAME RUSSELL KRAFT		22b EMBALMER'S LICENSE NO. 293100105		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) 1010711		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10101 Broadway Crown Point, In 46307 FDH83002445
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. CARCINOMA OF COLON WITH LIVER METASTASES Approximate Interval Between Onset and Death: 1 1/2 YRS				
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 DECEASENT 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>[Signature]</i>			29c MEDICAL LICENSE NO. 01630107	29d DATE SIGNED (Month, Day, Year) 11-6-95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. B Baraj, 25 E. 89th, Merrillville, IN 46410				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) November 6, 1995
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 000535		34e 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. 900 km cash		