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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): HERMAN A. PARKER
2. SEX: MALE
3a. TIME OF DEATH: 10:50 A
3b. DATE OF DEATH (Month, Day, Yr.): NOVEMBER 28, 2000
4. *SOCIAL SECURITY NUMBER: 339-22-2891
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): JUNE 17, 1929
7. BIRTHPLACE (City and State or Foreign Country): CHICAGO, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
9a. PLACE OF DEATH (Check only one. See instructions.): ☐ HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; ☐ OTHER ☐ Nursing Home ☐ Residence ☒ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): VNA MARY E. BARTZ HOSPICE CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: VALPARAISO
9d. COUNTY OF DEATH: PORTER
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): BETTY STULL
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): FOREMAN
12b. KIND OF BUSINESS/INDUSTRY: INLAND STEEL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: SCHERERVILLE
13d. STREET AND NUMBER: 1621 TERRACE DR.
13e. ZIP CODE: 46375
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: WHITE
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☐ No ☒ 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): HERMAN F. PARKER
19. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN AMBROSIUS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): BETTY PARKER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1621 TERRACE DR. SCHERERVILLE, IN. 46375
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 1, 2000 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: CHARLES WELLS
22b. EMBALMER'S LICENSE NO.: FD01042372
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Eli Wenglicz
24b. LICENSE NUMBER (of Licensee): FD01008300
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307

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. ISCHEMIC CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF)
b. CORONARY ARTERY DISEASE
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

Approximate Interval Between Onset and Death

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

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

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: Rakesh Kansal MD
29c. MEDICAL LICENSE NO.: IN 01038984
29d. DATE SIGNED (Month, Day, Year): 12/11/00

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Rakesh Kansal MD 3100 - 45th Street Highland IN 46322
31. HEALTH OFFICER'S SIGNATURE: Mary A. Bobeske MD
32. DATE FILED (Month, Day, Year): DECEMBER 4, 2000

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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

FILED
APR 29 2004
STEPHEN R. STIGLICH
COUNTY AUDITOR

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