



ATTENTION ESTATE: Disclosure of the information we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 95-270

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) <b>JOHN J. SOPO</b>				2. SEX <b>MALE</b>		3a. TIME OF DEATH <b>8:30A M</b>		3b. DATE OF DEATH (Month, Day, Yr) <b>SEPTEMBER 17, 1995</b>							
4. *SOCIAL SECURITY NUMBER <b>312-14-2580A</b>		5a. AGE—Last Birthday (Years) <b>73</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) <b>DEC. 26, 1921</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>ISKE, HUNGARY</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>YES</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA 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) <b>ST. CATHERINE HOSPITAL</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>EAST CHICAGO</b>				9d. COUNTY OF DEATH <b>LAKE</b>							
10. MARITAL STATUS (Specify) <b>MARRIED</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>MARY FEKETE</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>GAS CHROMATOGRAPHER</b>				12b. KIND OF BUSINESS/INDUSTRY <b>E.C.I. REFINERY</b>							
13a. RESIDENCE—STATE <b>INDIANA</b>		13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN, OR LOCATION <b>WHITING</b>				13d. STREET AND NUMBER <b>1728 SHERIDAN AVENUE</b>							
13e. ZIP CODE <b>46394</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>WHITE</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>					
18. FATHER'S NAME (First, Middle, Last) <b>ALEX SOPO</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH WAYO</b>											
20a. INFORMANT'S NAME (Type/Print) <b>MRS. MARY SOPO</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1728 SHERIDAN, WHITING, IN 46394</b>				20c. Relationship <b>WIFE</b>							
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <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) <b>SEPTEMBER 21, 1995 ST. JOHN CEMETERY</b>				21c. LOCATION—City or Town, State <b>HAMMOND, INDIANA</b>							
22a. EMBALMER'S NAME <b>MARTIN A. DYBEL</b>				22b. EMBALMER'S LICENSE NO. <b>FDE01019456</b>				23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b. LICENSE NUMBER (of Licensee) <b>FDE01019456</b>				25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BARAN &amp; SON, INC. FDH83007267 1235-119TH ST., WHITING, IN 46394</b>							
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>Acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Severe rheumatoid arthritis</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Hypertension essential</i> DUE TO (OR AS A CONSEQUENCE OF) d. <i>Arteriosclerotic heart disease</i> 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) <b>N/A</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>	
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. <b>01023357</b>		29d. DATE SIGNED (Month, Day, Year) <b>SEPT. 18, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>J.P. MANGHAS, M.D., 4716 INDIANAPOLIS BLVD., EAST CHICAGO, IN 46312</b>										31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) <b>9-20-95</b>			
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							
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.											

IVRA-20 (5/03)

\* 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

Local No. 203

State No. \_\_\_\_\_

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>MARY ANN SOPO</b>			2. SEX <b>FEMALE</b>		3a. TIME OF DEATH <b>10:47AM</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>OCTOBER 17, 2002</b>
4. *SOCIAL SECURITY NUMBER <b>305-20-2896A</b>		5a. AGE—Last Birthday (Years) <b>76</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>OCT. 5, 1926</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>WHITING, INDIANA</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a. PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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) <b>ST. CATHERINE HOSPITAL</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>EAST CHICAGO</b>		9d. COUNTY OF DEATH <b>LAKE</b>	
10. MARITAL STATUS (Specify) <b>WIDOWED</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>
13a. RESIDENCE—STATE <b>INDIANA</b>		13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN, OR LOCATION <b>WHITING</b>		13d. STREET AND NUMBER <b>1728 SHERIDAN AVENUE</b>
13e. ZIP CODE <b>46394</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>WHITE</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____				
18. FATHER'S NAME (First, Middle, Last) <b>JOHN FEKETE</b>			19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY WAYO</b>			
20a. INFORMANT'S NAME (Type/Print) <b>MR. JOHN J. SOPO, JR.</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1728 SHERIDAN, WHITING, IN 46394</b>		20c. Relationship <b>SON</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <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) <b>OCTOBER 21, 2002 ST. JOHN CEMETERY</b>		21c. LOCATION—City or Town, State <b>HAMMOND, INDIANA</b>	
22a. EMBALMER'S NAME <b>HENRY J. BLAKE</b>			22b. EMBALMER'S LICENSE NO. <b>FDE01019406</b>		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) <b>FDE01019456</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BARAN &amp; SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394</b>	
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. <b>Cancer of lung</b> <span style="float: right;">Approximate Interval Between Onset and Death <b>~ 3 years</b></span>						
b. <b>Parathryroid disease</b>						
c. <b>Diabetes Mellitus</b>						
d. <b>Myopatriemia</b>						
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>Superior vena cava syndrome. Respiratory acidosis</b>						
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>			28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>	
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. <b>01047947</b>		29d. DATE SIGNED (Month, Day, Year) <b>OCT. 18, 2002</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>KANAYO K. ODELUGA, M.D., 915 W. CHICAGO AVE., EAST CHICAGO, IN 46312</b>						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) <b>10/24/02</b>
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	
			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.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER