INDIANA STATE DEPARTMENT OF HEALTH

ical No. 2002-93 — CERTIFICATE OF DEATH — State No. .....

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

1 DECEASED—NAME (First, Middle, Last): Robert L. Kuva	2 SEX: Male	3a TIME OF DEATH: 8:52 P M	3b DATE OF DEATH (Month, Day, Yr): August 18, 1993	
4 SOCIAL SECURITY NUMBER: 310-22-5044	5a AGE—Last Birthday (Years): 64	5b UNDER 1 YEAR: Months Days	5c UNDER 1 DAY: Hours Minutes	6 DATE OF BIRTH (Mo. Day. Yr): Jul. 29, 1929
7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indian				
8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	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): 3412 Eder St.	9c CITY, TOWN OR LOCATION OF DEATH: Highland	9d COUNTY OF DEATH: Lake		
10 MARITAL STATUS (Specify): Married	11 SURVIVING SPOUSE (If wife, give maiden name): Frances Dado	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use "retired"): Power Station Engineer	12b KIND OF BUSINESS/INDUSTRY: Steel Co.	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Highland	13d STREET AND NUMBER: 3412 Eder St.	
13e ZIP CODE: 46322	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.)
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): Louis Kuva	19 MOTHER'S NAME (First, Middle, Maiden Surname): Anna Zajac			
20a INFORMANT'S NAME (Type/Print): Frances Kuva	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3412 Eder St. Highland, Indiana	20c Relationship: Wife		
21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 21, 1993 Concordia Cemetery	21c LOCATION—City or Town, State: Hammond, Indiana		
22a EMBALMER'S NAME: David Peterson	22b EMBALMER'S LICENSE NO.: FDO 8601585	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes		
24a SIGNATURE OF FUNERAL DIRECTOR: A Kuper	24b LICENSE NUMBER (of Licensee): FDO 1014511	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Highland, Indiana FDH 300-7500		

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)

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

a. Metastatic Lung Carcinoma — DUE TO (OR AS A CONSEQUENCE OF)

b. — DUE TO (OR AS A CONSEQUENCE OF)

c. — DUE TO (OR AS A CONSEQUENCE OF)

d.

Approximate Interval Between Onset and Death

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)
NO	NO	

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

MAY 17 2007

FILED

MAY 17 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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	29d DATE SIGNED (Month, Day, Year)
Stuart Klein	0103179	8/19/93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Stuart Klein 7905 Calumet Munster Ind 46321 MD

31 HEALTH OFFICER'S SIGNATURE

32 DATE FILED (Month, Day, Year): Aug. 19, 1993

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				006533 11-LP

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) CS

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.