Key # (12) 14-58-11

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.

Local No. 111-06

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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): KENNETH CHARLES HOFFMAN
2. SEX: MALE
3a. TIME OF DEATH: 2:03 P M
3b. DATE OF DEATH (Month, Day, Yr.): MAY 5, 2006
4. *SOCIAL SECURITY NUMBER: 723-07-5972
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo, Day, Yr): JUNE 23, 1922
7. BIRTHPLACE (City and State or Foreign Country): DYER, INDIANA
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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARGARET MERCY - SOUTH
9c. CITY, TOWN, OR LOCATION OF DEATH: DYER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CATHERINE HIGGINS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): BUSINESS OWNER
12b. KIND OF BUSINESS/INDUSTRY: GROCERY STORE
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: DYER
13d. STREET AND NUMBER: 1938 LAKE ST.
13e. ZIP CODE: 46311
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): LEO HOFFMAN
19. MOTHER'S NAME (First, Middle, Maiden Surname): MAGDALENA BOHLING

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CATHERINE HOFFMAN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1938 LAKE ST. DYER, INDIANA 46311
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 9, 2006 NORTHWEST INDIANA CREMATION SERVICE
21c. LOCATION—City or Town, State: CROWN POINT, INDIANA
22a. EMBALMER'S NAME: SCOTT PREWITT
22b. EMBALMER'S LICENSE NO: FD01006861
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Jack Miller
24b. LICENSE NUMBER (of Licensee): FD20400030
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL HOME FH83001504, 1920 HART ST. DYER, INDIANA 46311

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Renal failure	2 weeks
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF) b.	urinary track infection	2 weeks
DUE TO (OR AS A CONSEQUENCE OF) c.	Pneumonia	2 weeks
DUE TO (OR AS A CONSEQUENCE OF) d.		

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

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):
[X] 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: W Mc...
29c. MEDICAL LICENSE NO: 01055863A
29d. DATE SIGNED (Month, Day, Year): 5/9/06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Wassim Atassi - 7900 Columbia AVE, Hammond, IN - 46324

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan M Bast D.O.
32. DATE FILED (Month, Day, Year): May 9, 2006

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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): 023111
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.

$11 CS

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