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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

006-27-17-0048-0010

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED-NAME (First, Middle, Last)	William Leonard Ford
2. SEX	Male
3a. TIME OF DEATH	5:42pm M
3b. DATE OF DEATH (Month, Day, Yr)	February 25, 2007
4. *SOCIAL SECURITY NUMBER	303-32-1754
5a. AGE - Last Birthday (Years)	74
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	May 22, 1932
7. BIRTHPLACE (City and State or foreign Country)	Hobart, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1955
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)	Horton VNA Hospice
9c. CITY, TOWN OR LOCATION OF DEATH	Valparaiso
9d. COUNTY OF DEATH	Porter
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maden name)	Mary Hamilton
12a. DECEDENT'S USUAL OCCUPATLON (Give kind of work done during most of working life. Do not use retired)	US Steel
12b. KIND OF BUSINESS/ INDUSTRY	Steel Industry
13a. RESIDENCE — STATE	Indiana
13b. COUNTY	Porter
13c. CITY, TOWN, OR LOCATION	VALPARAISO
13d. STREET AND NUMBER	382 N. 650 West
13e. ZIP CODE	46385
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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

Field	Value
18. FATHER'S NAME (First, Middle, Last)	William D. Ford
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Mable W. Jones

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	Mary Knox-Ford
20b. MAILING ADDRESS (Street and Number or Rual Route Number, City or Town, State, Zip Code)	382 N. 650 West Valparaiso, Indiana 46385
20c. Relationship	Wife

DISPOSITION

Field	Value
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	March 1, 2007 Graceland Cemetery
21c. LOCATION—City or Town, State	Valparaiso, Indiana
22a. EMBALMER'S NAME:	RUSSELL A. KRAFT, JR.
22b. EMBALMER'S LICENSE NO.	FD29300105
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Russell A. Kraft [signature]
24b. LICENSE NUMBER (of Licensee)	FD29300105
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Kraft Funeral Services and Crematory, Inc. FH10000005 370 N County Line Rd. Hobart, IN 46342

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.

		Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	Ca lung with liver metastasis	
Conditions, If any, which gave rise to the immediate cause, starting the underlying cause last	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.

Field	Value
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 openion, 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 openion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

Field	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature] MD
29c. MEDICAL LICENSE NO.	01031667
29d. DATE SIGNED (Month, Day, Year)	3/6/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Pimpa J. Tara 8127 Merrillville Rd Merrillville, Indiana

HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	Mary A. Babcock MD [signature]
32. DATE FILED (Month, Day, Year)	March 6, 2007

FILED MAR 2008

Field	Value
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, 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.	

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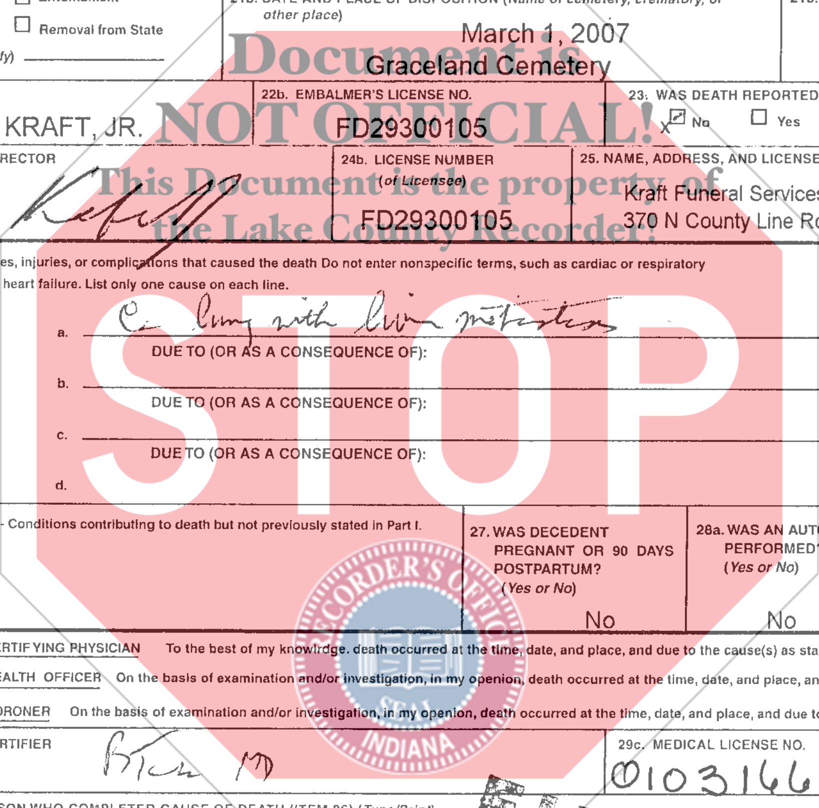

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