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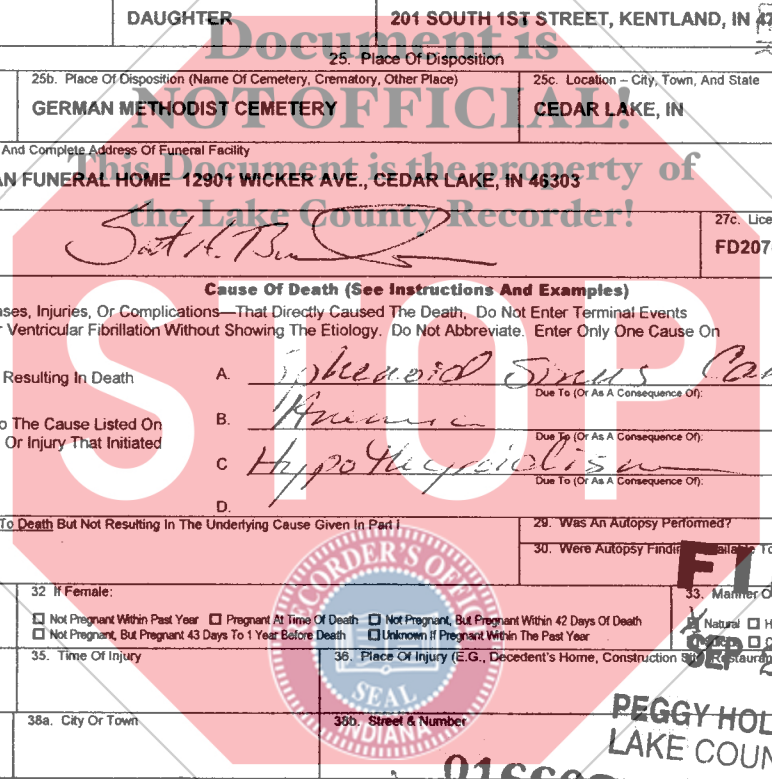


INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3205-06

State No.

1. Decedent's Legal Name (First, Middle, Last) BOBBY L. CONRAD				1a. Maiden Last Name (if Female)		2. Sex M	3. Time Of Death 5:53 AM	4. Date Of Death (Month/Day/Year) SEPTEMBER 22, 2008	
5. Social Security Number 309-42-5262	6a. Age Yrs 68	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year) October 26, 1939		8. Birthplace (City And State Or Foreign Country) EAST CHICAGO, IN	
9. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)				
11. Facility Name (If Not Institution, Give Street And Number) 13945 BUTTERNUT STREET									
12. City Or Town, State, And Zip Code CEDAR LAKE, IN 46303					13. County Of Death LAKE		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name PEARL JOAN CONRAD			15a. (If Wife) Give Maiden Last Name WAY			16. Decedent's Usual Occupation JANITOR		17. Kind Of Business/Industry CUSTODIAL	
18. Residence - State IN		18a. County LAKE		18b. City Or Town CEDAR LAKE					
18c. Street And Number 13945 BUTTERNUT STREET						18d. Apt. No.	18e. Zip Code 46303	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education High school graduate or GED completed		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino			21. Decedent's Race White				
22. Father's Name (First, Middle, Last) EDGAR CHARLES CONRAD				23. Mother's Name (First, Middle, Last) DOROTHEA SYLVIA CONRAD			23a. Mother's Maiden Last Name HENDRICKSON		
24. Informant's Name KAREN CATLIN		24a. Relationship To Decedent DAUGHTER		24b. Mailing Address (Street And Number, City, State, Zip Code) 201 SOUTH 1ST STREET, KENTLAND, IN 47951					
25. Place Of Disposition									
25a. Method Of Disposition: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) GERMAN METHODIST CEMETERY			25c. Location - City, Town, And State CEDAR LAKE, IN				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility BURDAN FUNERAL HOME - 12901 WICKER AVE., CEDAR LAKE, IN 46303						27a. Funeral Home License Number: FH83002461	
27b. Signature Of Indiana Funeral Service Licensee: <i>Susan W. Bert</i>						27c. License Number (Of Licensee) FD20700051			
28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Inoperable Sinus Cancer</u> Due To (Or As A Consequence Of): B. <u>Brain</u> Due To (Or As A Consequence Of): C. <u>Hypertension</u> Due To (Or As A Consequence Of): D. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I.									
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
31. Did Tobacco Use Contribute To Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Workplace)			37. Injury At Work?		
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number			38c. Apt. No.	38d. Zip Code	
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
41. Signature, Of Person Certifying Cause Of Death: <i>Morgan F. Hing</i>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: DR Morgan F Hing CANCER HEALTH Tx Ctr, 11030 45th Ave, Minister, IN 46321						44. License Number 1041301		45. Date Certified 9-23-2008	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <i>Susan W Bert, D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year) September 24, 2008			



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STATE DEPARTMENT OF HEALTH
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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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