



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000002

EDR No 000000619112

State No

1. Decedent's Legal Name (First, Middle, Last) VERNON J KASPAR				1a. Maiden Name (if female)		2. Sex MALE		3. Time Of Death 02:47 AM		4. Date Of Death (Month/Day/Year) 01/05/2018											
5. Social Security Number [REDACTED]		6a. Age - Yrs 95		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) 01/15/1922		8. Birthplace (City and State or Foreign Country) SIoux CITY, IA							
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 type="checkbox"/> Decedent's Home <input checked="" type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)									
11. Facility Name (If Not Institution, Give Street and Number) MILNER COMMUNITY HEALTH CARE CENTER INC												12. City Or Town, State, And Zip Code ROSSVILLE, IN, 46065		13. County Of Death CLINTON		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown					
15. Surviving Spouse's Name				15a. Last Name Before First Marriage				16. Decedent's Usual Occupation OWNER				17. Kind Of Business/Industry MEDIA									
18. Residence - State INDIANA				18a. County CLINTON				18b. City Or Town FRANKFORT				18c. Street And Number 5285 WEST GASLINE ROAD		18d. Apt. No.		18e. Zip Code 46041		18f. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
19. Decedent's Education BACHELOR'S DEGREE (BA, AB, BS)				20. Decedent Of Hispanic Origin NOT HISPANIC				21. Decedent's Race White				22. Parent's Name (First, Middle, Last) CHARLES KASPAR				23a. Parent's Last Name Before First Marriage GOERING					
24. Informant's Name RUSSELL KASPAR				24a. Relationship To Decedent SON				24b. Mailing Address (Street And Number, City, State, Zip Code) 1348 EAST TULIP TREE DRIVE, FRANKFORT, IN 46041				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): ST LUKE CEMETERY				25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) FRANKFORT, IN				25c. Location - City, Town, And State	
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				27. Name And Complete Address Of Funeral Facility GOODWIN FUNERAL HOME INCORP., 200 SOUTH MAIN STREET, FRANKFORT, IN 46041								27a. Funeral Home License Number: FH83002241									
27b. Signature Of Indiana Funeral Service Licensee: WILLIAM G. MILLER, BY ELECTRONIC SIGNATURE								27c. License Number (Of Licensee): FD08600393													
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. END STAGE RENAL DISEASE YEARS Due to (Or As A Consequence Of): Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) 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. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I DM										29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No										31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" 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																	
34. Date Of Injury (Month/Day/Year)				35. Time Of Injury				36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)				37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No									
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: JOHN MARTIN THOMAS, BY ELECTRONIC SIGNATURE										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: JOHN MARTIN THOMAS, 1 W. SCHOLER DRIVE, LAFAYETTE, IN 47909										44. License Number 01044009A				45. Date Certified 01/08/2018							
46. Additional Funeral Service Provider:										47. *Akas											
48. Signature of Local Health Officer: STEPHEN D. THARP, VIA ELECTRONIC SIGNATURE										49. For Registrar Only - Date Filed (Month/Day/Year): JAN 08 2018											

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)