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THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. James Ghoston

EMBALMER'S NAME

FUNERAL DIRECTOR'S SIGNATURE

STATE HEALTH DEPARTMENT

LAKE COUNTY FUNERAL HOME

Local No. 746589

968

SEP 2 1983

CONDITIONS OF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

USUAL RESIDENCE WHERE DECEASED LIVED, IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

DECEASED

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

INDIANA STATE BOARD OF HEALTH  
MEDICAL CERTIFICATE OF DEATH

State No. 36303

|   |  |   |   |   |  |   |
|---|--|---|---|---|--|---|
| DECEASED—NAME<br>1. <b>MARY BLANCO</b>  |  |   | SEX<br>2. <b>FEMALE</b>   |   | DATE OF DEATH (MONTH DAY YEAR)<br>3. <b>SEPTEMBER 24, 1983</b> |   |
| RACE—(e.g. White, Black, American Indian, etc.)<br>4. <b>White</b>  |  | AGE—Last Birthday (Yrs)<br>5a. <b>66</b>  |   | DATE OF BIRTH (Mo. Day, Yr.)<br>6. <b>Nov. 25, 1916</b>                   |  | COUNTY OF DEATH<br>7. <b>Lake</b>   |
| CITY, TOWN OR LOCATION OF DEATH<br>7b. <b>Hobart</b>  |  |   | HOSPITAL OR OTHER INSTITUTION—Name (if not in either, give street and number)<br>7c. <b>St. Mary Mercy Hospital</b> |   |  | IF HOSP OR INST. Indicate DOA OP Emer. Rm. Inpatient (Specify)<br>8. <b>Inpatient</b>               |
| STATE OF BIRTH (If not in U.S.A. name country)<br>8. <b>Indiana</b>   |  | CITIZEN OF WHAT COUNTRY<br>9. <b>USA</b>  |   | MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>10. <b>Married</b> |  | SURVIVING SPOUSE (If wife, give maiden name)<br>11. <b>Pedro</b>                                    |
| SOCIAL SECURITY NUMBER<br>13. <b>317 42 7509</b>  |  |   | USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>14a. <b>Housewife</b>     |   | KIND OF BUSINESS OR INDUSTRY<br>14b. <b>Self</b>               |   |
| RESIDENCE—STATE<br>15a. <b>Indiana</b>  |  | COUNTY<br>15b. <b>Lake</b>  |   | CITY, TOWN OR LOCATION<br>15c. <b>Gary</b>                                |  | IS RESIDENCE ON A FARM?<br>15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| STREET AND NUMBER<br>15d. <b>8101 Locust Ave.</b>   |  |   | IS RESIDENCE ON A FARM?<br>15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   |  | INSIDE CITY LIMITS (SPECIFY YES OR NO)<br>15f. <b>yes</b>   |
| IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC.<br>15g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |   |  |   |
| FATHER—NAME FIRST MIDDLE LAST<br>16. <b>Michael Apostol</b>   |  |   | MOTHER—MAIDEN NAME FIRST MIDDLE LAST<br>17. <b>Anna Colugaisable</b>  |   |  |   |
| INFORMANT—NAME (Type or Print) RELATIONSHIP<br>18a. <b>Pedro Blanco Husband</b>   |  | MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP<br>18b. <b>8101 Locust Ave. Gary, Indiana</b>   |   |   |  |   |
| BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br>19a. <b>Burial</b>   |  | CEMETERY OR CREMATORY—FUNERAL HOME<br>19b. <b>Calumet Park Cem.</b>   |   | LOCATION CITY OR TOWN STATE<br>19c. <b>Merrillville, Ind.</b>             |  |   |
| DATE (MONTH DAY YEAR)<br>20a. <b>Sept. 28th, 1983</b>   |  | FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN STATE, ZIP)<br>20b. <b>Stilainovich &amp; Wiatroluk 4213 Broadway Gary, Ind</b> |   |   |  |   |
| To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated<br>21a. (Signature) <b>Donald M. Phillips, M.D.</b>    |  |   |   | DATE SIGNED (Mo., Day, Yr.)<br>21b. <b>SEP 28 1983</b>                    |  | HOUR OF DEATH<br>21c. <b>4:55 AM</b>  |
| NAME OF ATTENDING PHYSICIAN (Type or Print)<br>21d. <b>Dr. Phillips</b>   |  |   |   |   |  |   |
| MAILING ADDRESS—PHYSICIAN<br>21e. <b>1356 South Lake Park Ave. Hobart, Indiana</b>  |  |   |   |   |  |   |
| HEALTH DEPT. SIGNATURE<br>21f. <b>James Freely M.D.</b>   |  |   |   |   | DATE RECEIVED BY LOCAL HEALTH OFFICER<br>22b. <b>9-26-83</b>   |   |
| PART I (a) <b>cardiac arrest</b> (Interval between onset and death: <b>minutes</b> )  |  |   |   |   |  |   |
| PART I (b) <b>congestive heart failure</b> (Interval between onset and death: <b>months</b> )   |  |   |   |   |  |   |
| PART I (c) <b>arteriosclerotic disease</b> (Interval between onset and death: _____)  |  |   |   |   |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)  |  |   |   |   |  | AUTOPSY (Specify Yes or No)<br>24. <b>No</b>  |

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