

992459

INDIANA STATE BOARD OF HEALTH

George Corberry
8505 Broadway
Merrillville

Local No.

989126

CERTIFICATE OF DEATH

State No.

TYPE/PRINT

DECEASED—NAME FIRST MIDDLE LAST VIOLET M. CORLEY 2. SEX Female 3 DATE OF DEATH (Mo. Day, Yr) July 15, 1988

PERMANENT SOCIAL SECURITY NUMBER 308-05-8719

5a AGE—Last Birthday (Years) 69 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Month, Day, Year) 5-31-1919 7 BIRTHPLACE (City and State or Foreign Country) GARY, INDIANA

YEAR LAST SERVED IN U.S. ARMED FORCES?

9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL Inpatient ER/Outpatient DOA OTHER Nursing Home Residence Other (Specify)

DECEDENT FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER

9c CITY, TOWN OR LOCATION OF DEATH HOBART 9d COUNTY OF DEATH LAKE

MARITAL STATUS—Married Never Married, Widowed, Divorced (Specify) Married

11 SURVIVING SPOUSE (If wife, give maiden name) GORDON CORLEY 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOME MAKER 12b. KIND OF BUSINESS/INDUSTRY NONE

RESIDENCE—STATE INDIANA

13b COUNTY LAKE 13c CITY, TOWN, OR LOCATION HOBART 13d STREET AND NUMBER 3112 WISCONSIN STREET

INSIDE CITY LIMITS? (Yes or no) YES

13f FARM NO 13g ZIP CODE 46342 14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No Yes Specify: 15 RACE—American Indian, Black, White, etc. (Specify) WHITE 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5+)

FATHER'S NAME (First, Middle, Last) ANTONY VARGO (DECEASED)

18. MOTHER'S NAME (First, Middle, Maiden Surname) IRMA JUHASZ (DECEASED)

INFORMANT'S NAME (Type/Print) GORDON CORLEY

19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 WISCONSIN STREET, HOBART, INDIANA 46342 19c Relationship SPOUSE

METHOD OF DISPOSITION

20a. METHOD OF DISPOSITION Burial Cremation Removal from State Donation Other (Specify) 20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) July 19, 1988 CALVARY CREMATORY 20c. LOCATION—City or Town, State PORTAGE, INDIANA

SIGNATURE OF FUNERAL DIRECTOR

21a. SIGNATURE OF FUNERAL DIRECTOR [Signature] 21b LICENSE NUMBER (of Licensee) FDE1041083 22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOME-FDH3003069 600 WEST OLD RIDGE RD., HOBART, IN 4

PHYSICIAN ONLY

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title < [Signature] 23b. LICENSE NUMBER 010372 23c. DATE SIGNED (Month, Day, Year) 7-19-88

TIME OF DEATH

24 TIME OF DEATH 06:23P M 25. DATE PRONOUNCED DEAD (Month, Day, Year) JULY 15, 1988 26 WAS REFERRED TO MEDICAL EXAMINER/CORONER? (Yes/No) YES

PART I

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Severe congestive heart failure b. Congestive cardiomyopathy c. Obstructive lung disease

CAUSE OF DEATH

27a. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 27b. Enter the date, time, and place of death. 27c. Enter the date, time, and place of death. 27d. Enter the date, time, and place of death.

CERTIFIER

28a. CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. 28b. PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. 28c. MEDICAL EXAMINER CORONER 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) and manner as stated.

SIGNATURE AND TITLE OF CERTIFIER

29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] 29c. LICENSE NUMBER 010372 29d. DATE SIGNED (Month, Day, Year) JUL 19 1988

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) JACK ZIEGLER MD, 8909 BROADWAY, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER'S SIGNATURE

31. HEALTH OFFICER'S SIGNATURE [Signature] 32. DATE FILED (Month, Day, Year) JUL 19, 88

MANNER OF DEATH

33 MANNER OF DEATH Natural Pending Investigation Accident Could not be Determined Suicide 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) 34f LOCATION (Street and Number or Rural Route Number, City or Town, State)

SEE INSTRUCTIONS

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) 34f LOCATION (Street and Number or Rural Route Number, City or Town, State)

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AUDITOR LAKE COUNTY

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CORONER OR MEDICAL EXAMINER USE ONLY

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7400 N. Chi. A. 277

FILED

JUN 26 1988

Anna N. Antos

FILED

AUG 5 1988

Anna N. Antos
AUDITOR LAKE COUNTY

WILLIAM A. BLASTICK
CORONER, LAKE COUNTY, INDIANA
JUL 27 1 35 PM '88
JUL 15 2 01 PM '88
LULIAN A. BLASTICK
CORONER, LAKE COUNTY, INDIANA
JUL 15 2 01 PM '88