89-0840 INDIANA STATE BOARD OF HEALTH

Local No. 095136 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): JOHN JOSEPH BONO
2. SEX: Male
3a. TIME OF DEATH: 6:30 PM
3b. DATE OF DEATH (Month Day Yr): December 8, 1989
4. SOCIAL SECURITY NUMBER: 308-28-9103
5a. AGE—Last Birthday (Years): 59
5b. UNDER 1 YEAR (Months Days):
5c. UNDER 1 DAY (Hours Minutes):
6. DATE OF BIRTH (Mo Day Yr): November 25, 1930
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A US VETERAN? Yes
8b. YEAR LAST SERVED IN US ARMED FORCES? 1953
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): 907 East 52nd Avenue
9c. CITY, TOWN OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Joann Furlin
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Crane Operator
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 907 East 52nd Avenue
13e. ZIP CODE: 46410
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? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc)
16. RACE—American Indian, Black, White, etc (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):

PARENTS

18. FATHERS NAME (First, Middle, Last): Frank Bono
19. MOTHERS NAME (First, Middle, Maiden Surname): Rose Bertruse

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Joann Bono
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 907 E. 52nd Ave., Merrillville, IN 46410
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 12, 1989 Calvary Cemetery
21c. LOCATION—City or Town, State: Portage, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO: 1042372
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John L. Pruzin
24b. LICENSE NUMBER (of Licensee): 1007231
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF)
b. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Coronary Artery disease
DUE TO (OR AS A CONSEQUENCE OF)
d. Diabetes Mellitus

Conditions if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

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)

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 opinion, 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 opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. MEDICAL LICENSE NO: 01036861
29d. DATE SIGNED (Month Day Year): 12-12-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JONG H Kim M.D., 5490 Broadway, Merrillville, IN 46410 (219) 887-7325

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD MPH
32. DATE FILED (Month, Day, Year): DEC. 13 1989

CORONER USE ONLY

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, farm 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

FILED
APR 12 1990
AUDITOR LAKE COUNTY
4.00

Key # 43-424-36 Georgia Heights Addition W. 2 Ft. Lot 20 Ex. W. 2 Ft. Lot 20

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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