Local No. 282 095567

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Mar. 29 1990 — Franklin D. Speredakos M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Ramon	Suarez	Male	10:25 a.m.	March 27, 1990

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo. Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
467-44-5064	65			Sept 16, 1924	Juanacatlan, Mexico

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
No	—	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Margaret Hospital	Hammond	Lake

10 MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Raquel Serna	Steel Worker	Steel

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	4424 Baltimore Avenue

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46327	[ ] No [X] Yes	[X] No [ ] Yes	USA	[ ] No [X] Yes — Mexican	White	6	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Jose Suarez	Maria DeJesus Galvan

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Raquel Suarez	4424 Baltimore, Hammond, Indiana 46327	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	March 30, 1990 St. John Cemetery	Hammond, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Keith D. Anthony	01011911	[ ] No [X] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Keith D Anthony	01011911	Anthony & Dziadowicz FH 83002835 4404 Cameron, Hammond, IN 46327

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (due to, or as a consequence of)	Congestive Cardiac myopathy.	
a. DUE TO (OR AS A CONSEQUENCE OF)	Cardiac Dysrhythmia	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d.		

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

CERTIFIER

29a CERTIFIER (Check only one)

[X] 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
M Krad MD	29360	March 29, 1990

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
M. Krad, M.D. 509 Ridge Road, Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Franklin D. Speredakos M.D.	MAR 29 1990

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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, etc.

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