095869

Local No. 434

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.
MAY 1 6 1988 — Franklin D. Olemuda M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: FIRST: MARY; MIDDLE: Julia; LAST: VANZO
2. SEX: Female
3. DATE OF DEATH (Mo. Day Yr.): May 14, 1988
4. SOCIAL SECURITY NUMBER: 312-60-8501
5a. AGE—Last Birthday (Years): 80
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month Day Year): March 1,1908
7. BIRTHPLACE (City and State or Foreign Country): Universal, Indiana
8. YEAR LAST SERVED IN U.S. ARMED FORCES? No
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Vigile Vanzo
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 4012 Torrence Ave.
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46327
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [X] No [ ] Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Vincent Verhonik
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unavailable

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Vigile Vanzo
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4012 Torrence Ave. Hammond, In. 46327
19c. Relationship: Husband

DISPOSITION

20a. METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 17, 1988 Calumet Park Cemetery
20c. LOCATION—City or Town, State: Merrillville, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: Lawrence Miller
21b. LICENSE NUMBER (of Licensee): FDE1006015
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Fagen-Miller Funeral Gardens Inc. FDH3003035 2828 Highway Ave. Highland, In. 46322

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 12:20 P M
25. DATE PRONOUNCED DEAD (Month, Day, Year): May 14, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH (SEE INSTRUCTIONS)

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Arteriosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Diabetes mellitus
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Atrial fibrillation

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

FILED APR 13 1990 — Anna M. Anton, AUDITOR LAKE COUNTY

RECORDED — ROBERT ... RECORDER — 56 PM '90 — STATE OF INDIANA S.S. NO.

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
[ ] 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.
[X] 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.
[ ] 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan Jones DO
29c. LICENSE NUMBER: 640
29d. DATE SIGNED (Month, Day, Year): May 15, 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): A.J. Jones, D.O. 3881 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Olemuda M.D.
32. DATE FILED (Month, Day, Year): MAY 1 6 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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)

001144

4.00

Left margin: Hammond Steel City Cem Ac 20 Sec 5 Lot# 34-33-20

SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1