

INDIANA STATE BOARD OF HEALTH 7870 B'way Ste 1

Allen H. G. Cochran

Local No. 1160-90 104152

CERTIFICATE OF DEATH

State No. 46110

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

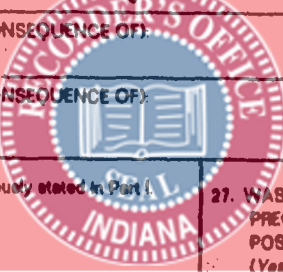
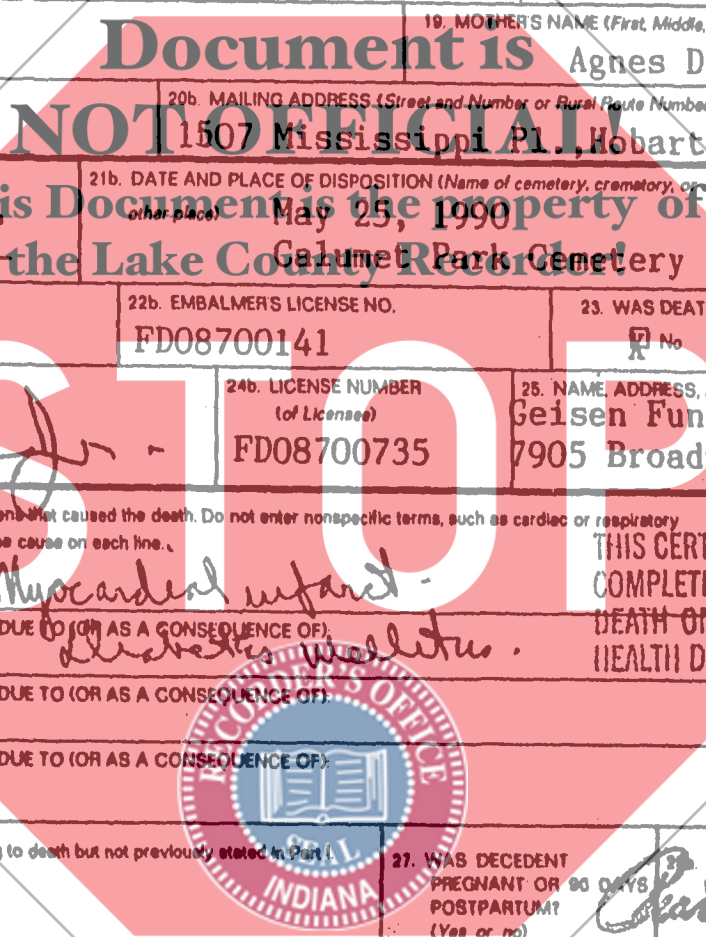
CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

#17-24865
Briarwood Inc. Rt 65

1. DECEASED—NAME (First, Middle, Last) Lottie J. Chiabai				2. SEX Female		3a. TIME OF DEATH 7:01 A.M.		3b. DATE OF DEATH (Month, Day, Yr) May 23, 1990	
4. SOCIAL SECURITY NUMBER 317-09-5788		5a. AGE—Last Birthday (Years) 71		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) June 27, 1918	
7. BIRTHPLACE (City and State or Foreign Country) South Bend, Indiana		8a. WAS DECEDENT A U.S. VETERAN? No							
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. 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	
10. MARITAL STATUS (Specify) WIDOW		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) Homemaker			12b. KIND OF BUSINESS/INDUSTRY Own Home		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hobart			13d. STREET AND NUMBER 420 Briarwood Lane		
13e. ZIP CODE 46342		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12		18. FATHER'S NAME (First, Middle, Last) Stanley Rudnicki							
19. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Drozda		20a. INFORMANT'S NAME (Type/Print) Agnes Juris							
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1507 Mississippi Pl., Hobart, Indiana 46342				20c. Relationship Daughter					
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 25, 1990 Galumet Park Cemetery			21c. LOCATION (City, Town, State) Merrillville, Indiana			
22a. EMBALMER'S NAME: Dennis P. Lapine				22b. EMBALMER'S LICENSE NO. FD08700141		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes JUN 05 1990			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Robert A. Craig</i>			24b. LICENSE NUMBER (of Licensee) FD08700735		25. NAME, ADDRESS, AND PHONE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH# 007362 7905 Broadway, Merrillville, IN 46410				
26. PART I. Enter the disease, 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) Myocardial infarct - diabetes mellitus.									
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last									
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				28. WAS AN AUTOPSY PERFORMED? No			28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO RELEASE OF CAUSE OF DEATH? (Yes or no) No		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated									
<input type="checkbox"/> 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.									
<input type="checkbox"/> 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 <i>E.T. Pappas M.D.</i>						29c. MEDICAL LICENSE NO. 17761		29d. DATE SIGNED (Month, Day, Year) 5-31-90	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) E.T. Pappas, M.D., 6111 Harrison Street, Merrillville, Indiana 46410									
31. HEALTH OFFICER'S SIGNATURE <i>Charles Johnson</i>								32. DATE FILED (Month, Day, Year) JUN 1, 90	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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)					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					



FILED

JUN 1 1990

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