Alvin A. G. Rochau 7870 B'way Ste 1 Merrillville, In 46410

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 11660-90 **104152** State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
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?	—
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. 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	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Stanley Rudnicki
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Agnes Drozda

INFORMANT

Field	Entry
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

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	May 25, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State	Merrillville, Indiana
22a. EMBALMER'S NAME	Dennis P. Lapine
22b. EMBALMER'S LICENSE NO.	FD08700141
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Robert A. Craig Jr.
24b. LICENSE NUMBER (of Licensee)	FD08700735
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Geisen Funeral Home, Inc. FH[illegible]62 7905 Broadway, Merrillville, In 46410

FILED JUN 05 1990

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. Myocardial infarct
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.

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JUN 1 1990
Charles Johnson
LAKE COUNTY HEALTH COMMISSIONER

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	E T Pappas M.D.
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

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Charles Johnson
32. DATE FILED (Month, Day, Year)	JUN 1, 90

CORONER USE ONLY

Field	Entry
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, etc.	

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#17-24865 Crestwood Trace Lt 65

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