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INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

6775 Laurel Ave
JOLIET, Ind. 46368

Local No. 155-79

State No.

DECEASED—NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH MONTH DAY YEAR	
1. CHARLES				PETRITES	Male	January 24, 1979	
RACE—Is a White, Black, American Indian, or Spanish?		AGE—Last Birthday (Yrs)	UNDER 1 YEAR		DATE OF BIRTH (Mo., Day, Yr)	COUNTY OF DEATH	
4. White		60	MO.	DAYS	9-20-1918	7. Lake	
CITY, TOWN OR LOCATION OF DEATH				HOSPITAL OR OTHER INSTITUTION—Name of inst. or other place and number			IF HOSP. OR INST. (Specify No. or Inst.)
7b. Hobart				7c. St. Marys Medical Center			7d. Inpatient
STATE OF BIRTH (If not in U.S. name country)		CITIZEN OF WHAT COUNTRY		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	SURVIVING SPOUSE (If wife give maiden name)		
. Oklahoma		USA		10. Widowed	11. no		
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (See back of card during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY			
13. 312-05-2288		14. Retired Plant Protection		US Steel Corp.			
RESIDENCE—STATE		CITY, TOWN OR LOCATION					
18a. Indiana		18b. Lake		18c. Gary			
STREET AND NUMBER		IS RESIDENCE ON A FARM?		INSIDE CITY LIMITS (Specify Yes or No)			
18d. 4954		18e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18f. yes			
18. IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC							
18g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
FATHER—NAME		FIRST	MIDDLE	LAST	MOTHER—MAIDEN NAME		
16. Stanley				Petrites	17. Ann Radzville		
INFORMANT—NAME (Type or Print)				MAILING ADDRESS			
19. Daniel Petrites				19b. 4954 Massachusetts St., Gary, Indiana 46409			
BURIAL, CREMATION, REMOVAL, OTHER (Specify)		CEMETERY OR CREMATORY—FUNERAL HOME			LOCATION		
19a. Burial		19b. Calvary Cemetery			19c. Portage, Indiana		
DATE (MONTH, DAY, YEAR)		FUNERAL HOME—NAME AND ADDRESS			(STREET OR P.O. NO., CITY OR TOWN, STATE, ZIP)		
20. January 27, 1979		PRUZIN FUNERAL HOME, 6360 Broadway, Merr., Ind. 46410					
To the best of my knowledge, death occurred at the time, date, and place specified hereon				DATE SIGNED (Mo., Day, Yr)		HOURS OF DEATH	
21a. Signature: Daniel				21b. Jan 26, 1979		21c. 3:03 AM	
NAME OF ATTENDING PHYSICIAN (Type or Print)				M.D.			
21d. Donald M. Phillips				M.D.			
MAILING ADDRESS—PHYSICIAN							
21e. 1336 S. Lake Park, Hobart, Indiana 46342							
HEALTH OFFICER'S NAME				DATE RECEIVED BY LOCAL HEALTH OFFICER			
22a. Peter Tracy M.D.				22b. 1-30-79			
23. IMMEDIATE CAUSE (ONLY ONE CAUSE PER LINE (OR IN PARAGRAPHS))							
(a) renal failure							
(b) DUE TO OR AS A CONSEQUENCE OF							
(c) DUE TO OR AS A CONSEQUENCE OF							
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)							
24. AUTOPSY (Specify Yes or No)							
24. no							

SBH 06-003
REV. 10/77

FUNERAL HOME 245
 FUNERAL DIRECTORS LICENSE No. 723
 EMBALMER'S NAME
 SIGNATURE

Disposition Permit Issued
 Provisional Certificate
 Yes No



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