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9100960

Gene Matthews → 836 W. 39th Pl. Hobt, Ind 46342

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 91-91 ..... State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Annabelle Navarro
2. SEX: Female
3a. TIME OF DEATH: 1:20p M
3b. DATE OF DEATH (Month, Day, Yr): January 12, 1991
4. SOCIAL SECURITY NUMBER: 306-09-4769
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Aug. 5, 1915
7. BIRTHPLACE (City and State or Foreign Country): Gary, Ind.
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 ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Mary's Medical Center
9c. CITY, TOWN OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
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): Housewife
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 2901 W. 37th Ave.
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

18-144-7 v8
Possow's Add
Lot 7 & 8 Block

PARENTS

18. FATHER'S NAME (First, Middle, Last): Thomas Frangis
19. MOTHER'S NAME (First, Middle, Maiden Surname): Angeliki Athaneosopoulon

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Constance Huddleston
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 534 W. 37th Ave. Lot 225 Hobart
20c. Relationship: Granddaughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jan. 15, 1991 Calvary Cemetery
21c. LOCATION (City or Town, State): Portage, Indiana

RECEIVED FEB 3 1991 LAKE CO. COR. STATE OF INDIANA

22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO: FD 01010402
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S. Rendina Jr.
24b. LICENSE NUMBER (of Licensee): FD 01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina F. Home FH 83007819 5100 Cleveland Sp. Gary, In. 46408

THIS CERTIFIES THAT THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

26. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.
- a. IMMEDIATE CAUSE (Final disease or condition resulting in death): Congestive Heart Failure
- b. DUE TO (OR AS A CONSEQUENCE OF): coronary heart disease
- c. DUE TO (OR AS A CONSEQUENCE OF):
- d. DUE TO (OR AS A CONSEQUENCE OF):

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: Renal Failure

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
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 FEB 27 1991 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

29b. SIGNATURE AND TITLE OF CERTIFIER: R Billena Jr MD
29c. MEDICAL LICENSE NO.: 026067
29d. DATE SIGNED (Month, Day, Year): 1-14-91

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): R. BILLENA 5490 Broadway Merrillville In 46410
31. HEALTH OFFICER'S SIGNATURE: Robert Guthrie DO
32. DATE FILED (Month, Day, Year): January 13, 1991

CORONER 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

SBH08-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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