91016994

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 97 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Stella M. Mital
2 SEX: Female
3a TIME OF DEATH: 5;36pm
3b DATE OF DEATH (Month Day Yr): Mar 30 1991
4 SOCIAL SECURITY NUMBER: 307 01 0218
5a AGE—Last Birthday (Years): 73
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): Apr 11 1917
7 BIRTHPLACE (City and State or Foreign Country): East Chicago
8a WAS DECEDENT A US VETERAN? No
8b YEAR LAST SERVED IN US 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 Catherine Hospital
9c CITY TOWN OR LOCATION OF DEATH: East Chicago
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: East Chicago
13d STREET AND NUMBER: 4848 Baring Ave.
13e ZIP CODE: 46312
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? ☒ 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+)

PARENTS

18 FATHER'S NAME (First Middle Last): Joseph Stanaszek
19 MOTHER'S NAME (First Middle Maiden Surname): N/A

INFORMANT

20a INFORMANT'S NAME (Type Print): Raymond Mital
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 4848 Baring East Chicago In 46312
20c Relationship: Son

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Other (Specify) ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Apr 3 1991 Holy Cross Cemetery
21c LOCATION—City or Town, State: Calumet City Il
22a EMBALMER'S NAME: James W. Gholston
22b EMBALMER'S LICENSE NO: FD01004194
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: John B. Lesniak
24b LICENSE NUMBER (of Licensee): FD01005491
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lesniak FH83001601 East Chicago In

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. Arteriosclerotic Heart disease with dysrhythmia
DUE TO (OR AS A CONSEQUENCE OF)
b. Parkinson's Disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Anxiety and depression
DUE TO (OR AS A CONSEQUENCE OF)
d.

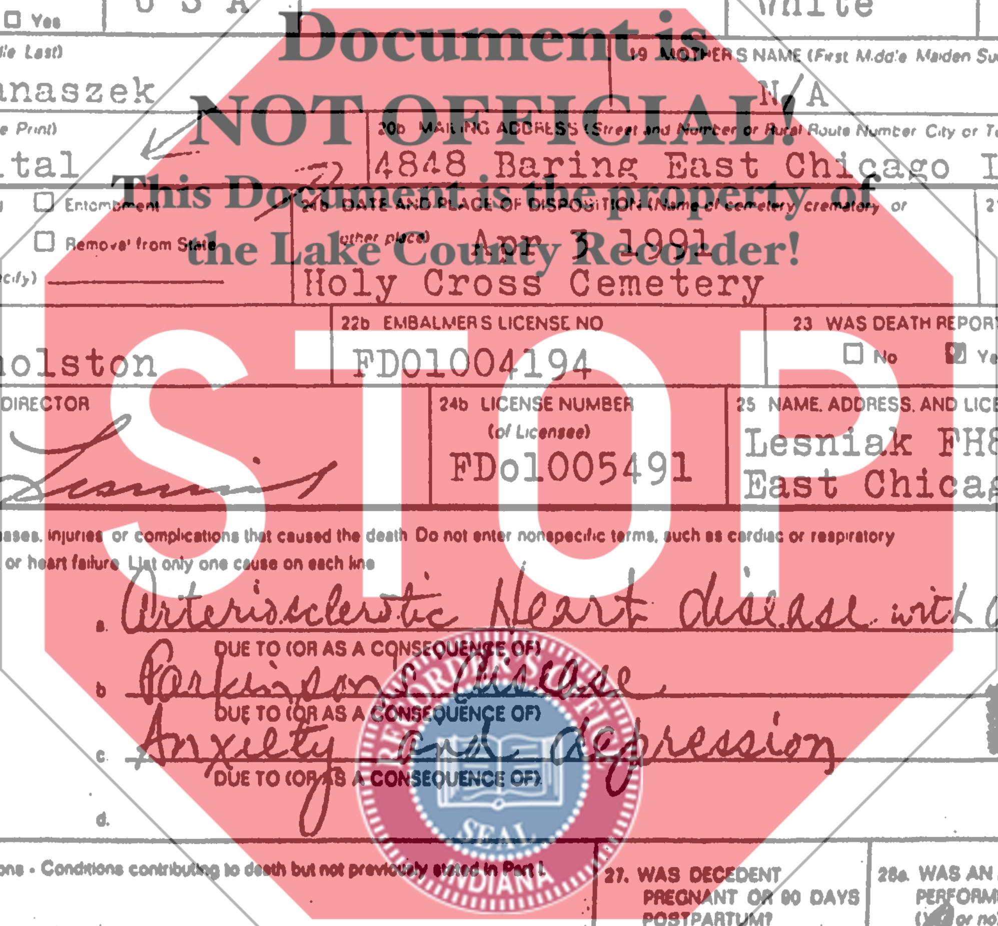
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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

FILED APR 10 1991
AUDITOR LAKE COUNTY



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STOP

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: J. P. Mangahas, M.D.
29c MEDICAL LICENSE NO: 01023357
29d DATE SIGNED (Month, Day, Year): April 2, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): J. P. Mangahaus MD 4716 Indianapolis Blvd East Chicago In 46312

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): 4-02-91

CORONER USE ONLY

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

00642 600

Margin stamp: STATE OF INDIANA/S.S. NO. LAKE COUNTY FILED FOR RECORD APR 10 1991 ROBERT

Margin notes (handwritten): Subdiv E 417 SW S.24 T37 R9; Cert L22 A21; 8 23-A21; Key 30-133-2 3

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