4cc

Key#3-83-2
Dalecarlia L2 Bl2

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No: 0829-91 91019305 State No: ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Ann Hornak
2. SEX	Female
3a. TIME OF DEATH	3:30P.M.
3b. DATE OF DEATH (Month, Day, Yr)	April 15, 1991
4. SOCIAL SECURITY NUMBER	311-58-2167
5a. AGE—Last Birthday (Years)	77
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	FEB 15, 1914
7. BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Anthony Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Crown Point
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Emery Hornak
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	At Home
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Lowell
13d. STREET AND NUMBER	563 S. Lakeview Dr.
13e. ZIP CODE	46356
13f. INSIDE CITY LIMITS	[X] No [ ] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	8

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Andrew Simko
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Eva Unknown

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Emery Hornak
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	563 S. Lakeview Dr., Lowell, IN 46356
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	APR 18, 1991 Calumet Park Cemetery
21c. LOCATION—City or Town, State	Merrillville, Indiana
22a. EMBALMER'S NAME	Robert P. Geisen
22b. EMBALMER'S LICENSE NO.	FD01000328
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Robert P. Geisen (signature)
24b. LICENSE NUMBER (of Licensee)	FD01000328
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FD83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Subarachnoid hemorrhage — Hours
DUE TO (OR AS A CONSEQUENCE OF):
b.
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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Hypertension; Diabetes mellitus - II

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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.
APR 17 1991
LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

29a. CERTIFIER (Check only one)
- [X] 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: (signature)
29c. MEDICAL LICENSE NO.: 60200066
29d. DATE SIGNED (Month, Day, Year): 4.16.91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Kirby D. Slifer DO, Medical Arts Center, 2970 Franciscan Dr., Crown Point, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: (signature)
32. DATE FILED (Month, Day, Year): APR 17, 91

CORONER USE ONLY

33. MANNER OF DEATH: [X] 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.

FILED
APR 23 1991
Anna N. Antone (signature)
AUDITOR LAKE COUNTY

600

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

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