PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

TIC 51496
THIS DOCUMENT NOT VALID
UNLESS STAMPED ON REVERSE SIDE

91023818

1 DECEASED—NAME (First, Middle, Last): JULIA D. RIBAR
2 SEX: FEMALE
3a TIME OF DEATH: 3:15 P M
3b DATE OF DEATH (Month, Day, Yr): DECEMBER 20, 1990
4 SOCIAL SECURITY NUMBER: 314-22-5886
5a AGE—Last Birthday (Years): 85
5b UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): FEBRUARY 10, 1905
7 BIRTHPLACE (City and State or Foreign Country): BRADDOCK, PENNSYLVANIA
8a WAS DECEDENT A U S VETERAN?: NO
8b YEAR LAST SERVED IN U S ARMED FORCES?: NO
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): FOUNTAINVIEW MANOR
9c. CITY, TOWN, OR LOCATION OF DEATH: PORTAGE
9d. COUNTY OF DEATH: PORTER
10 MARITAL STATUS (Specify): WIDOW
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MANAGER & COOK
12b KIND OF BUSINESS/INDUSTRY: GARY PUBLIC SCHOOL SYSTEM
13a RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c CITY, TOWN, OR LOCATION: HOBART
13d STREET AND NUMBER: 1621 W. 2nd STREET
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): 8; College (1-4 or 5+)
18 FATHER'S NAME (First, Middle, Last): PHILIP DOBOS
19. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA PUSVAK
20a INFORMANT'S NAME (Type/Print): MILDRED A. POGO
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3665 E. 32nd COURT, HOBART, IN. 46342
20c. Relationship: DAUGHTER
21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 22, 1990 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a EMBALMER'S NAME: GORDON L. JONES
22b EMBALMER'S LICENSE NO.: 1010710
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): 1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH#8600018 10101 BROADWAY, CROWN POINT, IN. 46307

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. MALIGNANT LYMPHOMA — Approximate Interval Between Onset and Death: 1 YEAR
DUE TO (OR AS A CONSEQUENCE OF)
b.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.
27. WAS DECEDENT PREGNANT OR 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

FILED
MAY 17 1991

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: A. Abey MD
29c. MEDICAL LICENSE NO.: 30830
29d. DATE SIGNED (Month, Day, Year): 12.21.90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type/Print): ANNESLEY ABEY, M. D., 6040 LUTE ROAD, PORTAGE, INDIANA 46368 (PHONE: 763-2606)
31 HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): December 28, 1990
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.

LAWYERS TITLE INS. CORP. ONE PROFESSIONAL CENTER SUITE 215 CROWN POINT, IN 46307

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

#17-243-10 #10 Bugle Ltd

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