

**INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH**

Local No. 9

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) AZNIV ANN SARKISIAN				2. SEX Female	3a. TIME OF DEATH 6:30p.	3b. DATE OF DEATH (Month, Day, Yr.) January 12, 1991	
4. SOCIAL SECURITY NUMBER 386-14-5469	5a. AGE—Last Birthday (Years) 66	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) March 9, 1924	7. BIRTHPLACE (City and State or Foreign Country) Highland Park Michigan		
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	9a. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		9b. FACILITY NAME (If not institution, give street and number) 1604 E. 142nd Street			
9c. CITY, TOWN, OR LOCATION OF DEATH East Chicago			9d. COUNTY OF DEATH Lake				
10. MARITAL STATUS (Specify) married	11. SURVIVING SPOUSE (If wife, give maiden name) Alex Sarkisian	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 1604 E. 142nd Street			
13e. ZIP CODE 46312	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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): unavailable College (1-4 or 5+): unavailable		
18. FATHER'S NAME (First, Middle, Last) Levon Buchakian			19. MOTHER'S NAME (First, Middle, Maiden Surname) Yeran Dagramajian				
20a. INFORMANT'S NAME (Type/Print) Alex Sarkisian		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 E. 142nd St. E. Chicago In. 46312		20c. Relationship Husband			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) January 15, 1991 Elmwood Cemetery		21c. LOCATION—City or Town, State Hammond Indiana			
22a. EMBALMER'S NAME Henry Blake		22b. EMBALMER'S LICENSE NO. FDO 103517		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Eric Prusiecki</i>		24b. LICENSE NUMBER (of Licensee) FDO1022431		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Prusiecki Funeral Home Inc. P.O. Box J East Chicago In. 46312 FMI3001562			
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) ANAPLASTIC ASTROCYTOMA, MIDBRAIN						6 months	
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							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? NO		28a. WAS AN AUTOPSY PERFORMED? NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) DNA			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Nicholas A. Vick M.D.</i>		29c. MEDICAL LICENSE NO. 1036040651(1L)		29d. DATE SIGNED (Month, Day, Year) 1/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) NICHOLAS A. VICK MD 2650 RIDGE EVANSTON IL 60201							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32. DATE FILED (Month, Day, Year) 1-15-91		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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.					

DECEASED
PARENTS
INFORMANT

DISPOSITION

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

30-488-19
 Prusiecki Lt 19 Bl 8



EXHIBIT
A955-B