6 CC;S

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Hodges, Davis, Gruenberg

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 1565-91 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Vivian D. Novotny
2. SEX: Female
3a TIME OF DEATH: 11:10 A M
3b DATE OF DEATH (Month Day Yr): July 28, 1991
4 SOCIAL SECURITY NUMBER: 303-24-5895
5a AGE—Last Birthday (Years): 71
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day. Yr): January 10,1920
7. BIRTHPLACE (City and State or Foreign Country): Duluth, Minnesota
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake Campus
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Charles H. Novotny
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): School Teacher
12b KIND OF BUSINESS/INDUSTRY: High School
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 3795 Fillmore Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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) College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First, Middle, Last): Nels Johnson
19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Vergoven

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Charles H. Novotny
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3795 Fillmore Street, Gary, Indiana 46408
20c Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 31, 1991 Calvary Cemetery
21c LOCATION—City or Town, State: Portage, Indiana
22a. EMBALMER'S NAME: ------
22b EMBALMER'S LICENSE NO: ------
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William C. Geisen
24b. LICENSE NUMBER (of Licensee): FD01003203
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc., FH83007762 7905 Broadway, Merrillville, In. 46410

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. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Artery Disease
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 contributing to death but not previously specified in Part I: Seizure disorder, Pulmonary edema

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): No

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: 01034369
29d. DATE SIGNED (Month, Day, Year): JULY-31-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Zafar U. Khalid, M.D., 9001 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): July 31, 1991

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.

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JUL 31 1991
Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
AUG 13 1991
Anna N. Anton
AUDITOR LAKE COUNTY

STATE OF INDIANA S.S. NO. LAKE COUNTY FILED FOR RECORD
AUG 14 1991 28 PM
ROBERT ... FREELAND RECORDER

Rec # 46-394-47 Rec Dat. Aug 4.45 Ack 1.47 - 1322