Local No. 1192-91

91055260

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Victoria Dentrono
2. SEX: female
3a. TIME OF DEATH: 4:25 P
3b. DATE OF DEATH (Month, Day, Yr): June 3, 1991
4. SOCIAL SECURITY NUMBER: 307-01-130[illegible]
5a. AGE—Last Birthday (Years): 94
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): September 18, 1896
7. BIRTHPLACE (City and State or Foreign Country): Italy
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. 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): Munster Med Inn
9c. CITY, TOWN OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Nick Dentrono
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 246 Conkey Street
13e. ZIP CODE: 46320
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): 6; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Mele
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Fatguso

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Nick Dentrono
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 246 Conkey St, Hammond, Indiana 46320
20c. Relationship: Husband

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): Elmwood Cemetery, June 6, 1991
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: James Porras
22b. EMBALMER'S LICENSE NO.: 1045964
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J Burns
24b. LICENSE NUMBER (of Licensee): 1045184
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Homes, Inc. 8415 Calumet Munster, In 3004968

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. Pneumonia
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

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Intracerebral Hemorrhage s/p (R) Temporal craniotomy ī (R) Temporal Lobectomy, CHF, (L) Humerus Fracture

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

ROBERT [illegible] RECORDER — OCT 31 9 50 — STATE OF IND. LAKE COUNTY FILED FOR RECORD

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: [signature]
29c. MEDICAL LICENSE NO.: 01-02-74-98
29d. DATE SIGNED (Month, Day, Year): 6/4/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. JOHN F. PEREZ 7905 CALUMET AV. MUNSTER, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): June 6, 1991

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Yr)
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, Yr)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED OCT 30 1991 — [signature] AUDITOR LAKE COUNTY

LAKE COUNTY HEALTH DEPT. — COMPLETE COPY OF DEATH ON FILE WITH THE LAKE COUNTY [illegible]

Handwritten (left margin): #34-20-33 Wmd Hts. Add. W. 1/2 Lt 35 All Lt 36 Bel

01617 60 E

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

Winterhoff + Assoc. 2/3344 Ridge Rd Lansing IL 60438