Atty Thomas D Ryan
4704 Dudley
E Chgo 46312

91055363

Local No. 191-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): ~~Peter R. Harretos~~ Peter R. Harretos
2 SEX: M
3a TIME OF DEATH: 5:10 A M
3b DATE OF DEATH (Month, Day, Yr): January 25, 1991
4 SOCIAL SECURITY NUMBER: 312-10-2582
5a AGE—Last Birthday (Years): 80
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo, Day, Yr): 9-15-1910
7 BIRTHPLACE (City and State or Foreign Country): Greece
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 ☐ Residence ☐ Other (Specify)
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): Mabel George
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Self-employed
12b KIND OF BUSINESS/INDUSTRY: Lounge Business
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: East Chicago
13d STREET AND NUMBER: 3702 Euclid Street
13e ZIP CODE: 46312
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? U.S.A.
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); College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First, Middle, Last): Gus C. Harretos
19 MOTHER'S NAME (First, Middle, Maiden Surname): Unavailable

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mabel Harretos
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3702 Euclid St, East Chicago, IN 46312
20c. Relationship: Wife

DISPOSITION

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): January 28, 1991 Ridgelawn Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO.: FD024372
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: David J. Pastrick
24b LICENSE NUMBER (of Licensee): FD08800012
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Oleska-Pastrick Funeral Home #155, 3934 Elm St, East Chicago, IN 46312

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. Uremia
DUE TO (OR AS A CONSEQUENCE OF):
b. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Dehydration
DUE TO (OR AS A CONSEQUENCE OF):
d. Poor oral intake related to organic Brain Syndrome

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

OCT 31 1991

AUDITOR LAKE COUNTY

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Diabetes Mellitus Type II; Arteriosclerosis; Congestive Heart Failure

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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: W Hermann MD
29c MEDICAL LICENSE NO: IN 20748
29d DATE SIGNED (Month, Day, Year): 1/25/91

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): W VITGHEMANN MD 7905 CALUMET AVE MUNSTER IN 46321
31 HEALTH OFFICER'S SIGNATURE: Robert L Guthrie MD
32 DATE FILED (Month, Day, Year): January 25, 1991

CORONER USE ONLY

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.

COMPLETE COPY OF DEATH ON FILE WITH THE LAKE

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

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