

03060950

INDIANA STATE BOARD OF HEALTH

Local No. 1844-90

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED - NAME (First Middle Last) **MABEL L. ZURCHER** 2 SEX **FEMALE** 3a TIME OF DEATH **9:30 P** 3b DATE OF DEATH (Month Day Year) **SEPTEMBER 9, 1990**

4 SOCIAL SECURITY NUMBER **389-24-4911** 5a AGE - Last Birthday (Years) **62** 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Mo Day Yr) **FEBRUARY 28, 1928** 7 BIRTHPLACE (City and State or Foreign Country) **VERONA, WISCONSIN**

DECEDENT

8a WAS DECEDENT A U.S. VETERAN? **NO** 8b YEAR ARMED SERVICED IN U.S. ARMED FORCES? **NONE** 9a PLACE OF DEATH (Check only one. See instructions) **HOSPITAL** Inpatient ER/Outpatient OOA **OTHER** Nursing Home Other (Specify) Residence

9b FACILITY NAME (If not institution give street and number) **COMMUNITY HOSPITAL** 9c CITY/TOWN OR LOCATION OF DEATH **MUNSTER** 9d COUNTY OF DEATH **LAKE**

PARENTS

10 MARITAL STATUS (Specify) **MARRIED** 11 SURVIVING SPOUSE (If wife give maiden name) **WILLIAM ZURCHER** 12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **HOMEMAKER** 12b KIND OF BUSINESS/INDUSTRY **HOME**

13a RESIDENCE-STATE **ILLINOIS** 13b COUNTY **COOK** 13c CITY/TOWN OR LOCATION **HOMEWOOD** 13d STREET AND NUMBER **19043 JOHNETHAN**

INFORMANT

13e ZIP CODE **60430** 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) **11** College (1-4 or 5+) **2 YRS**

DISPOSITION

18 FATHER'S NAME (First Middle Last) **WESLEY REUTER** 19 MOTHER'S NAME (First Middle, Maiden Surname) **HELEN CORDTS**

20a INFORMANT'S NAME (Type/Print) **WILLIAM ZURCHER** 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **19043 JOHNETHAN, HOMEWOOD, ILL. 60430** 20c Relationship **HUSBAND**

CAUSE OF DEATH

21a METHOD OF DISPOSITION Burial Cremation Donation Other (Specify) Removal from State 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **SEPTEMBER 11, 1990 PARK CREMATORY** 21c LOCATION - City or Town, State **PARK FOREST, ILL.**

CERTIFIER

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 HOME #3002819 5840 HOHMAN AVE. HAMMOND, IND (FOR RYAN F. H. HOMEWOOD, ILL.)**

HEALTH OFFICER

26 PART I Enter the disease, 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. **Cerebral vascular accident**
 IMMEDIATE CAUSE (Final disease or condition resulting in death) **NOV 23 1990**
 Conditions, if any, which give rise to the immediate cause, stating the underlying cause last
 DUE TO (OR AS A CONSEQUENCE OF)
 DUE TO (OR AS A CONSEQUENCE OF)
 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I
Survival of brain activity

CORONER USE ONLY

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**

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 *H. M. Mishoulam* 29c. MEDICAL LICENSE NO. **33507** 29d. DATE SIGNED (Month, Day, Year) **9-10-90**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IF M 28) (Type, Print) **DR. H. M. MISHOULAM, 9725 PRAIRIE AVE, HIGHLAND, IND. 46322**

31. HEALTH OFFICER'S SIGNATURE *Paul Johnson* 32. DATE FILED (Month, Day, Year) **SEP 10, 1990**

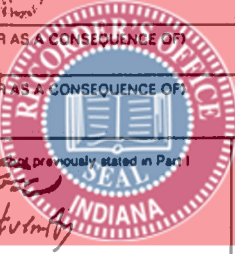
33. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide

34a. DATE OF INJURY (Month Day Year) 34b. TIME OF INJURY 34c. INJURY AT WORK? (Yes or no) 34d. DESCRIBE HOW INJURY OCCURRED

34a. PLACE OF INJURY - At home farm street factory office building etc (Specify) 34b. LOCATION (Street and Number or Rural Route Number City or Town State)

34c. DATE PHONOTYPED CEAD (Month Day Year) 34d. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

#39-359-1
Holographic Add to 1, 2, 3 be 1



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