93060950

Local No. 1844-90

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

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 Yr): 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
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): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; 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
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): WILLIAM ZURCHER
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: HOME
13a RESIDENCE—STATE: ILLINOIS
13b COUNTY: COOK
13c CITY, TOWN OR LOCATION: HOMEWOOD
13d STREET AND NUMBER: 19043 JOHNETHAN
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): 12; College (1-4 or 5+): 2 YRS

PARENTS

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

INFORMANT

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

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): SEPTEMBER 11, 1990 PARK CREMATORY
21c LOCATION—City or Town, State: PARK FOREST, ILL.
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)

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. cerebral vascular accident
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

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: Sarcoma of lower extremity
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)

NOV 23 1990
AUDITOR LAKE COUNTY

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.: 33507
29d DATE SIGNED (Month, Day, Year): 9-10-90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. H. M. MISHOULAM, 9725 PRAIRIE AVE, HIGHLAND, IND. 46322

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Basil Johnson
32 DATE FILED (Month, Day, Year): SEP 10, 90

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.

#39-350-1 Halzworths Addt 1,2,3 bl 1

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