92010243

61-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No: ....

PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): STELLA PAPPAS
2. SEX: FEMALE
3a. TIME OF DEATH: 6:09 A.M.
3b. DATE OF DEATH (Month Day Yr): FEBRUARY 18, 1991
4. SOCIAL SECURITY NUMBER: 307-20-2368
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): SEPT. 1, 1911
7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
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 ☐ Residence ☐ Other (Specify)
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): WIDOWED
11. SURVIVING SPOUSE (If wife, give maiden name): -
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): GENERAL
12b. KIND OF BUSINESS/INDUSTRY: U.S. STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: MERRILLVILLE
13d. STREET AND NUMBER: 6121 PENNSYLVANIA
13e. ZIP CODE: 46410
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?: XX 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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): STANLEY REDLINSKI
19. MOTHER'S NAME (First, Middle, Maiden Surname): LOTTIE RUTKOWSKA

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CLARE MATSEY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 113 SOUTH LEON AVE, ORLANDO, FLA 32720
20c. Relationship: SISTER-IN-LAW

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 21, 1991 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: HENRY BLAKE
22b. EMBALMER'S LICENSE NO.: FD01019406
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01001293
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH3004455-STILINOVICH & WIATROLIK 7535 TAFT ST., 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

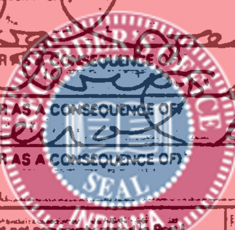
IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. [handwritten, illegible]
DUE TO (OR AS A CONSEQUENCE OF):
b. [handwritten, illegible]
DUE TO (OR AS A CONSEQUENCE OF):
c. [handwritten, illegible]
DUE TO (OR AS A CONSEQUENCE OF):
d.

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 resulting in the underlying cause given in Part I.

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

FILED
FEB 1 5 1992
[signature]
AUDITOR LAKE COUNTY



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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.

LAKE COUNTY HEALTH COMMISSIONER

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 0170887
29d. DATE SIGNED (Month, Day, Year): 2-18-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. JOHN KOLETTIS M.D. 8101 HARRISON ST. MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): February 18, 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.

00725

Handwritten margin notes: Cifali, Cifali 17 Main St Hobart Ctx; 165300-92-64; #15-74-24 Knollwood Ré 23 lot 3

TICOR TITLE INSURANCE Crown Point, Indiana

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