

92013076

INDIANA STATE BOARD OF HEALTH

P1 N2 SE NW  
S.25 T.36 R.9 .99AC  
Key # 39-51-21; Unit # 01

Local No. 0408-92

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN:  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle Last) <b>Mary Pantagides</b>		2 SEX <b>Female</b>		3a TIME OF DEATH <b>9:30am</b>		3b DATE OF DEATH (Month Day Year) <b>February 20, 1992</b>	
4 SOCIAL SECURITY NUMBER <b>119 03 5849</b>		5a AGE—Last Birthday (Years) <b>83</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr) <b>June 24, 1909</b>		7 BIRTH PLACE (City and State or Foreign Country) <b>New York N.Y.</b>					
8a WAS DECEDENT A US VETERAN? <b>NO</b>		8b YEAR LAST SERVED IN US ARMED FORCES?		9a PLACE OF DEATH (Check only one—See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution give street and number) <b>3920 Rodd Rd.</b>			9c CITY TOWN OR LOCATION OF DEATH <b>Calumet Twp IN</b>		9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Widowed</b>		11 SURVIVING SPOUSE (If wife give maiden name)		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Housewife</b>		12b KIND OF BUSINESS/INDUSTRY	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY TOWN OR LOCATION <b>Calumet Twp.</b>		13d STREET AND NUMBER <b>3920 Ross Rd.</b>	
13e ZIP CODE <b>46408</b>		13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)		16 RACE—American Indian, Black, White, etc. (Specify) <b>WHITE</b>		17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (11-4 or 5+) <b>8</b>			
18 FATHER'S NAME (First Middle Last) <b>Peter Novembre</b>				19 MOTHER'S NAME (First Middle Maiden Surname) <b>Julia (Unknown)</b>			
20a INFORMANT'S NAME (Type/Print) <b>Theresa Wells</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>3920 Ross Rd., Calumet Twp IN 46408</b>		20c Relationship <b>Daughter</b>	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place used) <b>Greenwood Cem. 1992</b>		21c LOCATION—City or Town, State <b>Tuckerton, New Jersey</b>			
22a EMBALMER'S NAME <b>Anthony S. Rendina Jr</b>		22b EMBALMER'S LICENSE NO. <b>FD01010402</b>		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr</i>		24b LICENSE NUMBER (of licensee) <b>FD01010402</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Rendina F. Home FH83007819 5100 Cleveland St. Gary, IN. 46408</b>			
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. <b>Severe aortic stenosis</b> DUE TO (OR AS A CONSEQUENCE OF) ABOVE CAUSE OF DEATH <b>ABOVE CAUSE OF DEATH</b> DUE TO (OR AS A CONSEQUENCE OF) ABOVE CAUSE OF DEATH <b>ABOVE CAUSE OF DEATH</b> DUE TO (OR AS A CONSEQUENCE OF) ABOVE CAUSE OF DEATH							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>no</b>							
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>no</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>no</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>no</b>			
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. 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. 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 <i>A. Gandhi</i>				29c MEDICAL LICENSE NO. <b>51029887</b>		29d DATE SIGNED (Month Day Year) <b>2-20-92</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>9122 COLUMBIA AVE. MUNSTER, IN. 46321 A. "Gandhi M.D."</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Robert N. Anton</i>						32 DATE FILED (Month Day Year) <b>February 21, 1992</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no) <b>FILED</b>	
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) <b>MAR 1 1992</b>			
34g DATE PRONOUNCED DEAD (Month Day Year)			34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <b>no</b>				

DECEDENT

PARENTS

INFORMANT

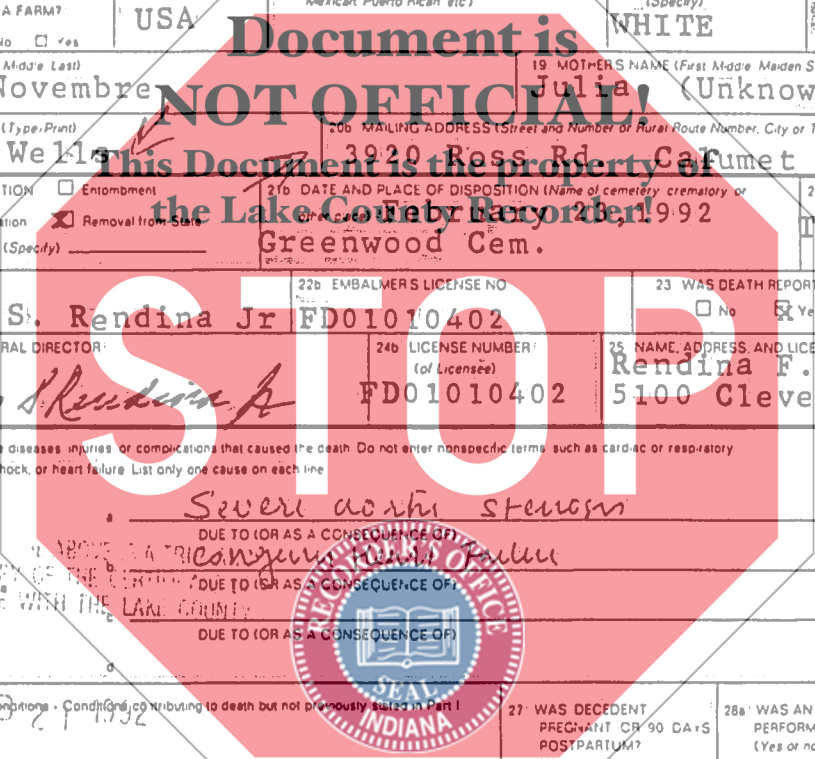
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



STATE OF INDIANA'S  
LAKE COUNTY  
FILED FOR RECORDE  
ROBERT N. ANTON  
FEB 21 1992