INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 48 92020660 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Lydia Rivera
2. SEX: Female
3a. TIME OF DEATH: 8:30pM
3b. DATE OF DEATH (Month Day Yr): February 7, 1991
4. SOCIAL SECURITY NUMBER: 314-26-8740
5a. AGE—Last Birthday: 59 (years)
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo Day Yr): Aug. 1, 1931
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Ind.
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 ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Catherine's Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Epifanio Rivera
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 207 Dallas St.
13e. ZIP CODE: 46406
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.): Mexican
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+):

PARENTS

18. FATHER'S NAME (First Middle Last): Jesse Baez
19. MOTHER'S NAME (First Middle Maiden Surname): Guadalupe Gutierrez

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Epifanio Rivera
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Dallas St. Gary, Ind. 46406
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): February 11, 1991 Ridgelawn Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.: FD01010402
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S Rendina Jr
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina F. Home FH 83007819 5100 Cleveland St. Gary, In. 46408

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. Cardiopulmonary arrest (CHF, pneumonia)
DUE TO (OR AS A CONSEQUENCE OF)
b. Stroke
DUE TO (OR AS A CONSEQUENCE OF)
c. Renal failure
DUE TO (OR AS A CONSEQUENCE OF)
d. Nephritis

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.

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):

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.: 5000 2119
29d. DATE SIGNED (Month, Day, Year): 2-11-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M. A. RAHMANY, M.D. 3801 RIDGE ROAD HIGHLAND, INDIANA 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): 2-12-91

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.

FILED APR 6 1992

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SBH06-004 State Form 10110 (R2/3-89)

[signature] DEP. CERT/PO 1 AUDITOR LAKE COUNTY

45-287-2 Lakewood on W. 5th Ave 3rd Add S. 9.32 ft L1, All L2, N. 9.68 ft L3 Bl. D

Taxes: Same

600

RECEIVED FOR RECORD APR 6 10 17 AM '92