92023774

Local No. 0917-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Deceased—Name (First, Middle, Last)	Richard Kent Matias
2. Sex	Male
3a. Time of Death	6:34 P.M.
3b. Date of Death (Month, Day, Yr)	April 22, 1991
4. Social Security Number	316-24-8288
5a. Age—Last Birthday (Years)	59
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo, Day, Yr)	Aug. 7, 1931
7. Birthplace (City and State or Foreign Country)	East Chciago, IN
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces?	1952
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)	8009 Screiber
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)	Cheryl Mastin
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Driver
12b. Kind of Business/Industry	Taxi
13a. Residence—State	IN
13b. County	Lake
13c. City, Town or Location	Munster
13d. Street and Number	8009 Schrieber
13e. Zip Code	46321
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? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	
College (1-4 or 5+)	1

PARENTS

Field	Value
18. Father's Name (First, Middle, Last)	George Charles Matias
19. Mother's Name (First, Middle, Maiden Surname)	Viola Roma Bakalyar

INFORMANT

Field	Value
20a. Informant's Name (Type/Print)	Cheryl Matias
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8009 Schrieber Munster, In 46321
20c. Relationship	Wife

DISPOSITION

Field	Value
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. Date and Place of Disposition (Name of cemetery, crematory or other place)	May 26, 1991 Concordia Cemetery
21c. Location—City or Town, State	Hammond, IN
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 (signature)
24b. License Number (of Licensee)	1045184
25. Name, Address, and License Number of Funeral Home	Burns-Kish Funeral Home#3004968 8415 Calumet Munster, IN 46321

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.

	Cause	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic ethanolism with cirrhosis of the liver.	Unknown
Due to (or as a consequence of) b.	gastrointestinal hemorrhage and hepatic failure.	
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

Field	Value
27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	No
28a. Was an Autopsy Performed? (Yes or no)	
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)	Yes

FILED APR 20 1994 — (signature), 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.

Field	Value
29b. Signature and Title of Certifier	Daniel D. Thomas MD (signature)
29c. Medical License No.	16120
29d. Date Signed (Month, Day, Year)	May 1, 1991
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

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

HEALTH OFFICER

Field	Value
31. Health Officer's Signature	Alexander S. Williams MD (signature)
32. Date Filed (Month, Day, Year)	May 1, 1991

MAY 06 1991

CORONER USE ONLY

Field	Value
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)	April 22, 1991
34h. Motor Vehicle Accident? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

Alexander S. Williams (signature)
LAKE COUNTY HEALTH COMMISSIONER

'92 APR 20 10 22 AM '94

FILED FOR RECORD LAKE COUNTY STATE OF IND.

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