92029687

Local No. 2147-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): PETER M. CALACCI
2. SEX: MALE
3a. TIME OF DEATH: 11:02A.M.
3b. DATE OF DEATH (Month, Day, Yr.): OCTOBER 22, 1991
4. SOCIAL SECURITY NUMBER: 306-03-7645
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): MAY 1 1914
7. BIRTHPLACE (City and State or Foreign Country): ITALY
8a. WAS DECEDENT A U.S. VETERAN? YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946
8c. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
8d. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
8e. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
8f. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MARY BIANCHI
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): DIRECTOR U.S.S.W. OF AMERICA UNION
12b. KIND OF BUSINESS/INDUSTRY: UNION 1010
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: SCHERERVILLE
13d. STREET AND NUMBER: 307 KING HENRY DR.
13e. ZIP CODE: 46375
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? ☒ 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): AMBROGIO CALACCI
19. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISA DITORRICE

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARY CALACCI
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 307 KING HENRY DR. SCHERERVILLE, IN
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DISPOSITION PLACE (Name of cemetery, crematory, or other place): OCTOBER 25, 1991 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: ELI VUJKO
22b. EMBALMER'S LICENSE NO.: FDO1008300
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Eli Vujko
24b. LICENSE NUMBER (or Licensure): FDO1008300
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME88800 7607W. LINCOLN HWY. CROWN POINT,

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. [illegible] DUE TO (OR AS A CONSEQUENCE OF): MAY 1 1992

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. [illegible] DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death: [illegible] months

PART II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to death but not previously stated in Part I.

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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. APR 21 1992
☐ 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: [illegible]
29c. MEDICAL LICENSE NO.: 23250
29d. DATE SIGNED (Month, Day, Year): OCTOBER 22 1991

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): BURTON GREENBERG M.D. 4320 FIR ST. EAST CHICAGO, INDIANA 46312
31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams, MD
32. DATE FILED (Month, Day, Year): OCT 23 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.

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

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