92040834

Local No. 2045-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): ELIZABETH DEMETER
2 SEX: FEMALE
3a TIME OF DEATH: 12:58A M
3b DATE OF DEATH (Month, Day, Yr): OCTOBER 8, 1991
4 SOCIAL SECURITY NUMBER: 306-28-2259
5a AGE—Last Birthday (Years): 90
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo, Day, Yr): Dec. 9, 1900
7 BIRTHPLACE (City and State or Foreign Country): Hungary
8a WAS DECEDENT A U.S. VETERAN? No
8b YEAR LAST SERVED IN U.S. ARMED FORCES? No
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c CITY, TOWN OR LOCATION OF DEATH: MUNSTER
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): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Home
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Munster
13d STREET AND NUMBER: 8510 Crestwood
13e ZIP CODE: 46321
13f INSIDE CITY LIMITS? [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY? U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): Joseph Bertalan
19 MOTHER'S NAME (First, Middle, Maiden Surname): Susanna Gal

INFORMANT

20a INFORMANT'S NAME (Type/Print): Helen Ochman
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8510 Crestwood Munster, IN 46321
Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 11, 1991 Cedar Park Cemetery
21c LOCATION—City or Town, State: Chicago, IL
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO: 1045964
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: I THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
24b LICENSE NUMBER (of Licensee): 1021590
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Homes#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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death): OCT 9 1991 Ventricular Fibrillation		15
a DUE TO (OR AS A CONSEQUENCE OF): Aortic Stenosis		10 yrs
b DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Heart Disease		40 yrs
c DUE TO (OR AS A CONSEQUENCE OF):		
d		

Conditions if any, which gave rise to the immediate cause, stating the underlying cause last: Alexander D. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Intertrochanteric Fracture R. femur

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): N/A

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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: David M Harvey MD
29c MEDICAL LICENSE NO: 17809
29d DATE SIGNED (Month, Day, Year): OCTOBER 9 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DAVID HARVEY M.D. 716 SEBERGER MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander D. Williams, M.D.
FILED
DATE FILED (Month, Day, Year): October 9, 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: JUN 23 1992
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): Aurora N. Ave
34g DATE PRONOUNCED DEAD (Month, Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

AUDITOR LAKE COUNTY 30865

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

DEA CERT/PD? Burke, Murphy, Costanza & Cuppy, 8585 Broadway, Merrillville, IN 46410-7601