Cora Seyfried

92042055

Local No. 214

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Date Issued Mar 13, 1992

Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Alvin Sago

2 SEX: Male

3a TIME OF DEATH: 5:39 A M

3b DATE OF DEATH (Month Day Yr): March 13, 1992

4 SOCIAL SECURITY NUMBER: 400-30-7739

5a AGE—Last Birthday (Years): 67

5b UNDER 1 YEAR (Months Days):

5c UNDER 1 DAY (Hours Minutes):

6 DATE OF BIRTH (Mo. Day Yr): March 9, 1925

7 BIRTHPLACE (City and State or Foreign Country): Breckinridge City, KY

8a WAS DECEDENT A US VETERAN?: Yes

8b YEAR LAST SERVED IN US ARMED FORCES?: N/A

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): 919 Becker St.

9c CITY TOWN OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Cora Allen

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Tankerman

12b KIND OF BUSINESS/INDUSTRY: Bargeline

13a RESIDENCE—STATE: IN

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Hammond

13d STREET AND NUMBER: 919 Becker St.

13e ZIP CODE: 46320

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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): JOhn Henry Sago

19 MOTHER'S NAME (First Middle Maiden Surname): Artie Mae Horsley

INFORMANT

20a INFORMANT'S NAME (Type/Print): Cora Sago

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 Becker St. Hammond, IN 46321

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Removal from State ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 16, 1992 Cloverport Cemetery

21c LOCATION—City or Town, State: Breckintridge City, KY

22a EMBALMER'S NAME: Kevine W. Kish

22b EMBALMER'S LICENSE NO: 1021590

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns

24b LICENSE NUMBER (of Licensee): 1045184

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home 5840 Hohman, Hammond, IN 46320

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. Vascular collapse — Approximate Interval Between Onset and Death: Unknown

DUE TO (OR AS A CONSEQUENCE OF): b. Due to arteriosclerotic heart and vascular disease

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

27 WAS DECEDENT PREGNANT OR 60 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)

☐ 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: Daniel D. Thomas, M.D., Coroner

29c MEDICAL LICENSE NO: 16120

29d DATE SIGNED (Month, Day, Year): March 13, 1992

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

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] FILED

32 DATE FILED (Month, Day, Year): March 13, 1992

CORONER USE ONLY

33 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

34a DATE OF INJURY (Month, Day, Year):

34b TIME OF INJURY:

34c INJURY AT WORK? (Yes or no): JUN 10 1992

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):

AUDITOR LAKE COUNTY

34g DATE PRONOUNCED DEAD (Month, Day, Year): March 13, 1992

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

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