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OFFICIAL COPY
MARION COUNTY HEALTH DEPARTMENT
3838 N RURAL ST. INDPLS, IN 46205
CERTIFICATE OF DEATH

Local No. 93011756

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Ruby Marie Gaitens
2. SEX: Female
3a. TIME OF DEATH: 11:37P. M
3b. DATE OF DEATH (Month Day Yr): March 02, 1992
4. SOCIAL SECURITY NUMBER: 315-09-6822
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): August 21, 1919
7. BIRTHPLACE (City and State or Foreign Country): Sharon, PA.
8a. WAS DECEDENT A US VETERAN? No
8b. YEAR LAST SERVED IN US 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. Vincent Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Indianapolis
9d. COUNTY OF DEATH: Marion
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:
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Whiting
13d. STREET AND NUMBER: 2116 Superior St.
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY: USA
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): 12yrs; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Patrick J. Rostin
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ruby A. Root Gaitens

INFORMANT

20a. INFORMANT'S NAME (Type/Print): James C. Gaitens JR.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Country Place Dr. Houston Texas77079
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 03-06-92 Concordia Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Lowell C. Doty
22b. EMBALMER'S LICENSE NO: FDO 1013222
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01009754
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Wilson-St. Pierre F.S. P.O.Box 33045 Indianapolis, IN. FH83003564

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. Atherosclerotic Cardiovascular Disease

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

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): n/a

FILED FEB 17 1993
[signature] AUDITOR LAKE COUNTY

SAMUEL ... RECORDER ... FEB 24 ... 1993

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: Dennis Nichols, MD
29c. MEDICAL LICENSE NO: 92-0254
29d. DATE SIGNED (Month, Day, Year): MAR 13 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dennis Nichols M.D./40 S. Alabama St.Indianapolis Marion Indiana 46204

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): MAR 5 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):
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): 08355
34g. DATE PRONOUNCED DEAD (Month, Day, Year): March 3, 1992
34h. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes, specify driver, passenger, pedestrian, etc: NO

#34-242-5 Lakeland Rt 5 Bl 3

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