

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 305
93012478

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

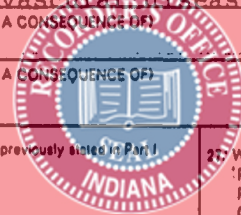
CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1 DECEASED—NAME (First Middle Last) Louis Luis R. Sanchez		2 SEX Male	3a TIME OF DEATH 3:57 PM	3b DATE OF DEATH (Month Day Yr) October 18, 1992	
4 SOCIAL SECURITY NUMBER 525-48-8024	5a AGE—Last Birthday (Years) 61	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Nov. 9, 1926	
7 BIRTHPLACE (City and State or Foreign Country) UNK Texas	8a WAS DECEDENT A US VETERAN? YES	8b YEAR LAST SERVED IN US ARMED FORCES? 1954	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
7b FACILITY NAME (If not institution, give street and number) St. Catherine Hospital		9c CITY TOWN OR LOCATION OF DEATH East Chicago	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Divorced	11 SURVIVING SPOUSE (If wife give maiden name) N/A	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Roller		12b KIND OF BUSINESS/INDUSTRY Steel Co.	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6707 Tennessee	
13e ZIP CODE 46320	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc) Mexican	16 RACE—American Indan Black White etc (Specify) White	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary; Secondary (10-12) 14 College (1-4 or 5 +) 14		18 FATHER'S NAME (First Middle Last) Unavailable			
19 MOTHER'S NAME (First Middle Maiden Surname) Unavailable		20a INFORMANT'S NAME (Type/Print) Julio Sanchez			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2137 W. 40th Pl. Griffith, Indiana		20c Relationship Son			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Ridgeway Cemetery		21c LOCATION—City or Town State Gary, Indiana	
22a EMBALMER'S NAME Edgar Gleim		22b EMBALMER'S LICENSE NO FDO 1016173		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511		24c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FTH: 300-7500	
25 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 <u>Vascular Collapse due to coronary arteriosclerotic</u> <u>undetermined</u> DUE TO (OR AS A CONSEQUENCE OF) b <u>heart and vascular disease</u> DUE TO (OR AS A CONSEQUENCE OF) c _____ DUE TO (OR AS A CONSEQUENCE OF) d _____					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
26		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)		29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 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 <i>[Signature]</i>		29c MEDICAL LICENSE NO		29d DATE SIGNED (Month, Day, Year) October 19, 1992	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Deborah Huseman, Chief Deputy, 2293 North Main Street, Crown Point, IN 46307					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) 10-20-92	
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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) October 18, 1992		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No			



FILED
FEB 24 1993

30-322-28 / St. Add Indiana Harbor, Lot 29, Bl 3

01333 600

Send to Bill's, 3726 Main St East Chicago, IN 46312
Mrs Sanchez