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INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 2610-92 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): SARAH GARCIA
2. SEX: FEMALE
3a. TIME OF DEATH: 2:30 P.M.
3b. DATE OF DEATH (Month Day Yr): DECEMBER 11, 1992
4. SOCIAL SECURITY NUMBER: 367-22-1022
5a. AGE—Last Birthday (Years): 66
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): OCTOBER 8, 1926
7. BIRTHPLACE (City and State or Foreign Country): HOLLAND, MICHIGAN
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MANLIO GARCIA, SR.
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: N/A
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 519 S. WAYNE ST. GARY, IN 46403
13e. ZIP CODE: 46403
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [ ] No [X] Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) MEXICAN
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): GONZALO CRUZ
19. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA GOMEZ

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MANLIO GARCIA, SR.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 519 S. WAYNE ST., GARY, IN 46403
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 15, 1992 CALVARY CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA 46368
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FDO 1006463
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO 1012048
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH 83005613 REES FUNERAL HOME, OLSON CHAPEL 5341 CENTRAL AVE., PORTAGE, IN 46368

CAUSE OF DEATH

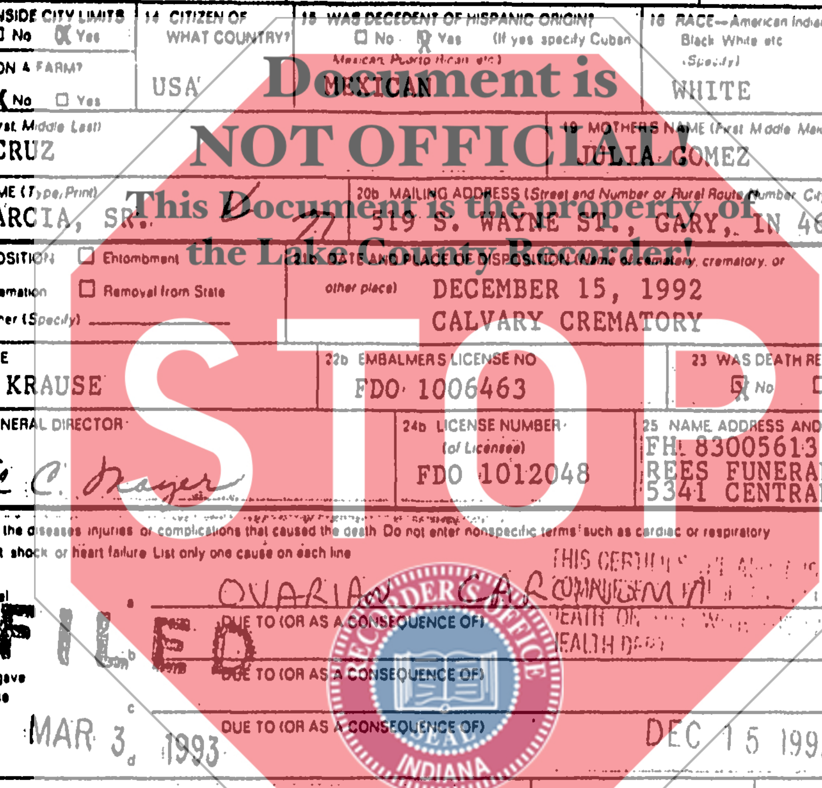
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. OVARIAN CARCINOMA — Approximate Interval Between Onset and Death: 3 YRS.
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF): d.

FILED MAR 3 1993

THIS CERTIFIES ... COMMISSIONER ... HEALTH ... COUNTY

DEC 15 1992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PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

[signature] AUDITOR LAKE COUNTY

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): NO

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: [signature]
29c. MEDICAL LICENSE NO.: 01030107
29d. DATE SIGNED (Month Day Year): 12-15-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): B. H. BARAI, M.D. 1225 E. 89th MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature], MD
32. DATE FILED (Month Day Year): December 15, 1992

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.

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SDH06-004 State Form 10110 (R/1-92) DEATHCERPD 1