Key No: 33-65-36

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT
Jan 12, 1993 — Date Issued — Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 33 93014337

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 Deceased—Name (First Middle Last)	Lucille F. Love
2 Sex	Female
3a Time of Death	11:59 P.
3b Date of Death (Month Day Yr)	January 10, 1993
4 Social Security Number	314-26-8861
5a Age—Last Birthday (Years)	74
5b Under 1 Year (Months / Days)	
5c Under 1 Day (Hours / Minutes)	
6 Date of Birth (Mo Day Yr)	September 5, 1918
7 Birthplace (City and State or Foreign Country)	Noicussa, Wisconsin
8a Was Decedent a US Veteran?	No
8b Year Last Served in US Armed Forces?	N/A
9a Place of Death (Check only one)	Hospital: XX Inpatient ☐ ER Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b Facility Name (If not institution give street and number)	St. Margaret Mercy Health Care North Cam.
9c City Town or Location of Death	Hammond
9d County of Death	Lake
10 Marital Status (Specify)	Widowed
11 Surviving Spouse (If wife give maiden name)	None
12a Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Laundry Sorter
12b Kind of Business/Industry	Cleaning
13a Residence—State	Indiana
13b County	Lake
13c City Town or Location	Hammond
13d Street and Number	137 Gostlin St.
13e Zip Code	46327
13f Inside City Limits	☐ No XX Yes
13g On a Farm?	XX No ☐ Yes
14 Citizen of What Country?	U.S.A.
15 Was Decedent of Hispanic Origin? (If yes specify Cuban Mexican Puerto Rican etc)	XX No ☐ Yes
16 Race—American Indian Black White etc (Specify)	White
17 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	[illegible]

PARENTS

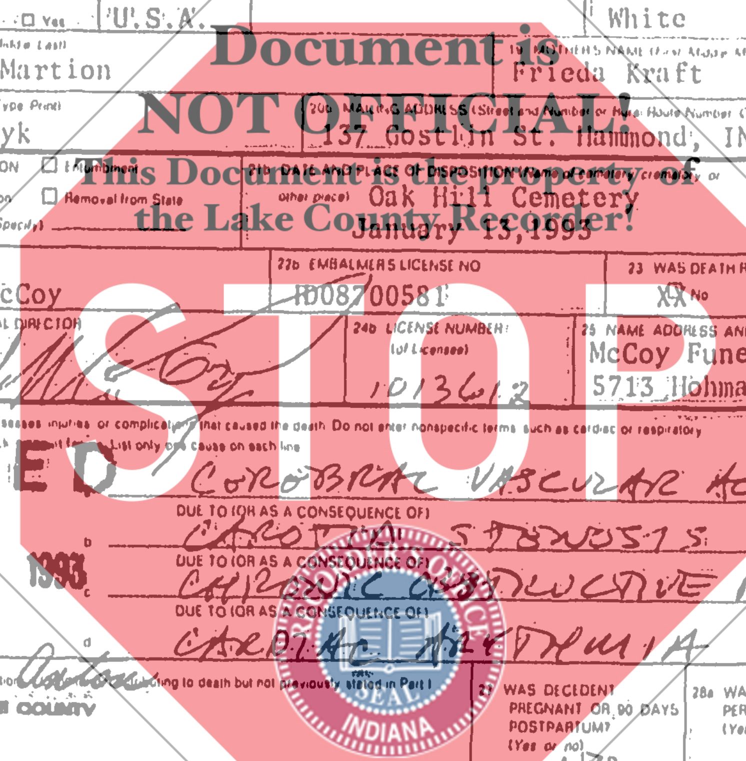
Field	Entry
18 Father's Name (First Middle Last)	Averal S. Martion
19 Mother's Name (First Middle Maiden Surname)	Frieda Kraft

INFORMANT

Field	Entry
20a Informant's Name (Type Print)	Mildred Slazyk
20b Mailing Address (Street and Number or Rural Route Number City or Town State Zip Code)	137 Gostlin St. Hammond, IN 46327
20c Relationship	Daughter

DISPOSITION

Field	Entry
21a Method of Disposition	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b Date and Place of Disposition (Name of cemetery crematory or other place)	Oak Hill Cemetery, January 13, 1993
21c Location—City or Town State	Hammond, Indiana
22a Embalmer's Name	David F. McCoy
22b Embalmer's License No	RD08700581
23 Was Death Reported to Coroner?	XX No ☐ Yes
24a Signature of Funeral Director	[signature]
24b License Number (of Licensee)	1013612
25 Name Address and License Number of Funeral Home	McCoy Funeral Chapel (287) 5713 Hohman Ave. Hammond, IN 56320


Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP
RECORDER'S OFFICE SEAL INDIANA

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.

	Cause	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a	Cerebral Vascular Accident	Days
Due to (or as a consequence of) b	Carotid Stenosis	Years
Due to (or as a consequence of) c	Chronic Obstructive Pul. Dis.	Years
Due to (or as a consequence of) d	Cardiac Arrhythmia	Days

Conditions if any giving rise to the immediate cause stating the underlying cause last.

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

FILED MAR 4 1993
[signature] AUDITOR LAKE COUNTY

27 Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	28a Was an Autopsy Performed? (Yes or no)	28b Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)
No	No	No

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	29c Medical License No	29d Date Signed (Month Day Year)
[signature] MD	161	Jan. 11/12/93

30 Name and Address of Person Who Completed Cause of Death (Item 26) (Type Print): Dr. C A Foreit 3831 Hohman Ave. Hammond, IN 46327

HEALTH OFFICER

31 Health Officer's Signature	32 Date Filed (Month Day Year)
Franklin [signature] M.D.	January 12, 1993

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

00127

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

Eschenbergs State Line Add. Ex. L.34 L.35 Bl.13 Bl.13

Key# 33-65-36

Henry S. Kowalczyk
5246 Hohman Ave Hm. 46320

6 00