93015992

Local No. 326-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Colleen Stalla
2 SEX: Female
3a TIME OF DEATH: 3:30pm
3b DATE OF DEATH (Month Day Yr): January 31, 1990
4 SOCIAL SECURITY NUMBER: 325-20-4278
5a AGE—Last Birthday (Years): 62
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day Yr): March 19, 1927
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: Not Applicabl
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): 12477 West 93rd Avenue
9c CITY, TOWN OR LOCATION OF DEATH: St. John
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Theodore Stalla
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: Own Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: St. John
13d STREET AND NUMBER: 12477 Wwst 93rd Avenue
13e ZIP CODE: 46373
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): Daniel Lawler
19 MOTHER'S NAME (First Middle Maiden Surname): Freda Uhle

INFORMANT

20a INFORMANT'S NAME (Type/Print): Theodore Stalla
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12477 West 93rd Avenue, St.John, Ind.46373
20c. Relationship: Husband

DISPOSITION

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): February 3, 1990 Holy Name Catholic Cemetery
21c LOCATION—City or Town, State: Cedar Lake, Indiana
22a EMBALMER'S NAME: Not Embalmed
22b EMBALMER'S LICENSE NO.: Not Applicable
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: William E. Burdan
24b LICENSE NUMBER (of Licensee): FD01007697
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burdan Funeral Home, FH83002461 12901 Wicker Ave., Cedar Lk, In 46303

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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 Severe ...
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

Approximate Interval Between Onset and Death

THIS CERTIFIES ... TRUE AND COMPLETE COPY OF THE CERTIFICATE OF ... ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

FILED MAR 11 1993

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

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)

LAKE COUNTY HEALTH COMMISSIONER

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: [signature]
29c MEDICAL LICENSE NO.: 20565
29d DATE SIGNED (Month, Day, Year): 1/31/90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul A Johnson MD
32. DATE FILED (Month, Day, Year): FEB 1 90

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)
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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Muenich's 1st Add. Lot 3
12-22-2-4-3

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD I

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