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INDIANA STATE DEPARTMENT OF HEALTH

Local No. ...0121-93..... **CERTIFICATE OF DEATH** State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Clara Minton

2 SEX: Female

3a TIME OF DEATH: 3:59 a

3b DATE OF DEATH (Month Day Yr): January 16, 1993

4 SOCIAL SECURITY NUMBER: 306 28 0027

5a AGE—Last Birthday (Years): 72

5b UNDER 1 YEAR (Months Days):

5c UNDER 1 DAY (Hours Minutes):

6 DATE OF BIRTH (Mo Day Yr): January 15, 1921

7 BIRTHPLACE (City and State or Foreign Country): Billings Montana

8a WAS DECEDENT A U.S. VETERAN?: No

8b YEAR LAST SERVED IN U.S. 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. Anthony Hospital

9c CITY TOWN OR LOCATION OF DEATH: Crown Point IN

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): John Minton

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Housewife

12b KIND OF BUSINESS/INDUSTRY:

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 2326 W 46th Ave

13e ZIP CODE: 46408

13f INSIDE CITY LIMITS ☐ No ☐ Yes

13g ON A FARM ☐ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: USA

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): Frederick Vogel

19 MOTHER'S NAME (First Middle Maiden Surname): Kathryn Estreich

INFORMANT

20a INFORMANT'S NAME (Type/Print): John Minton

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2326 W. 46th Ave Gary IN. 46408

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): January 18, 1993 Chapel Lawn Cemetery

21c LOCATION—City or Town State: Schererville IN.

22a EMBALMER'S NAME: Anthony S. Rendina

22b EMBALMER'S LICENSE NO: FD0101402

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Anthony S Rendina JR

24b LICENSE NUMBER (of Licensee): FD0101402

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: RendinaFuneral Home FH83007819 5100C leveland GAry IN 46408

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. Myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF): b.

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions if any which gave rise to the immediate cause of the cause stating the underlying cause last: THIS CERTIFIES THE ABOVE IS A TRUE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPT

Approximate Interval Between Onset and Death

FILED MAR 16 1993 Jesse N. Outlaw

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: JAN 19 1993

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no

28a WAS AN AUTOPSY PERFORMED? (Yes or no): no

WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: Milton Gaspari MD

29c MEDICAL LICENSE NO: 0103515

29d DATE SIGNED (Month Day Year): 11/8/93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Milton Gaspari's Lake Park Clinic Hobart, IN. 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander Williams 2nd MD

32 DATE FILED (Month Day Year): January 19, 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): 600

34g DATE PRONOUNCED DEAD (Month Day Year):

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

00813

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER.PD1

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3/16/93 sgt

39-26-53 E2.N2E2.E2NE.NW. Ex. S90ft. & Ex. E30 Ft. S.32. T36 R8

39-26-50, S.90ft. E½, N½, E½NW, NW; E.30 ft. S.32 T.36 R8. .278 AC.