4 175096 Ruble CP/GM/TICOR

93018020 INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2562-92 CERTIFICATE OF DEATH State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Mary Von Borstel
2 SEX: Female
3a TIME OF DEATH: 4:55 A.M.
3b DATE OF DEATH (Month Day Yr): December 4, 1992
4 SOCIAL SECURITY NUMBER: 305-70-5957
5a AGE—Last Birthday (Years): 88
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day, Yr): June 17, 1904
7 BIRTHPLACE (City and State or Foreign Country): Cedar Lake, Indiana
8a WAS DECEDENT A US VETERAN? No
8b YEAR LAST SERVED IN US 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): Lowell Health Care Center
9c CITY, TOWN OR LOCATION OF DEATH: Lowell
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Widowed
11 SURVIVING SPOUSE (If wife give maiden name):
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: Own Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Lowell
13d STREET AND NUMBER: 710 Michigan Ave.
13e ZIP CODE: 46356
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): Charles Froneck
19 MOTHER'S NAME (First Middle Maiden Surname): Mary Novak

INFORMANT

20a INFORMANT'S NAME (Type/Print): Robert D. Ruble
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12222 Cedar Lake Rd., Crown Point, Indiana 46307
20c Relationship: Son

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): December 5, 1992 Maplewood Cemetery
21c LOCATION—City or Town, State: Crown Point, Indiana
22a EMBALMER'S NAME: Fred Obarka
22b EMBALMER'S LICENSE NO: FV01016076
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Fred Obarka
24b LICENSE NUMBER (of Licensee): FD01016076
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Elleo-Brady Funeral Home, Inc. FH83000825 Cedar Lake, Indiana 46303

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)	Cerebral Vascular Accident	Days
DUE TO (OR AS A CONSEQUENCE OF)	Arteriosclerotic Vascular Disease	years
DUE TO (OR AS A CONSEQUENCE OF)	Insulin Dependent Diabetes Mellitus	years
DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

DEC 09 1992

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

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)

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

LAKE COUNTY HEALTH COMMISSIONER

29b SIGNATURE AND TITLE OF CERTIFIER: Richard Kreyss
29c MEDICAL LICENSE NO: 0200 002
29d DATE SIGNED (Month Day, Year): 12-9-92
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 2068 Lucas Parkway Lowell In 46356

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
FILED
32 DATE FILED (Month Day, Year): December 9, 1992

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:
MAR 22 1993
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):
Anna N. Antone
AUDITOR LAKE COUNTY
34g DATE PRONOUNCED DEAD (Month Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc
01132 600

SDH06-004 State Form 10110 (R3/3-92) DEATHCER-PD 1