INDIANA STATE BOARD OF HEALTH

Local No. 262 93020719

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): LOUISE ROSE VENDRAMIN

2 SEX: FEMALE

3a TIME OF DEATH: 11:30 A.M.

3b DATE OF DEATH (Month Day Yr): SEPT. 5, 1989

4 SOCIAL SECURITY NUMBER: 314-68-5711

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): SEPT. 17, 1916

7 BIRTHPLACE (City and State or Foreign Country): ILLINOIS

8a WAS DECEDENT A US VETERAN? NO

8b YEAR LAST SERVED IN US ARMED FORCES? NONE

8e 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. CATHERINE HOSPITAL

9c CITY TOWN OR LOCATION OF DEATH: EAST CHICAGO

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): MARRIED

11 SURVIVING SPOUSE (If wife give maiden name): ANGELO

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: EAST CHICAGO

13d STREET AND NUMBER: 4103 BUTTERNUT STREET

13e ZIP CODE: 46312

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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):
College (1 4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): GEORGE STRASHEK

19 MOTHER'S NAME (First Middle Maiden Surname): LOUISE GORENCE

INFORMANT

20a INFORMANT'S NAME (Type Print): ANGELO VENDRAMIN

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 4103 Butternut St. East Chicago, IN. 46312

20c Relationship: husband

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September 8, 1989 Calumet Park Cemetery

21c LOCATION—City or Town State: Merrillville, IND.

22a EMBALMER'S NAME: RAYMOND PRUSIECKI

22b EMBALMER'S LICENSE NO: FD01039517

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Raymond Prusiecki

24b LICENSE NUMBER (of Licensee): FD01039517

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Prusiecki Funeral Home, 46312 FH83001562, P.O. BOX 3, East Chicago IN

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

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiorespiratory Arrest — minutes

DUE TO (OR AS A CONSEQUENCE OF)
b. Terminal Acute Myocardial Infarction — minutes

DUE TO (OR AS A CONSEQUENCE OF)
c. Shock — hours

DUE TO (OR AS A CONSEQUENCE OF)
d. Sepsis and/or Cardiogenic — days

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

PART II Other significant conditions Conditions contributing to death but not previously listed in Part I
Pneumonia Hepatic Failure with Cirrhosis, Renal Failure Multifocal Cerebral Infarcts including Chronic Loss Type Congestive Heart Failure Asthma Chronic Obstructive

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)
[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: John Stephen Kelly MD

29c MEDICAL LICENSE NO: 0102 4423

29d DATE SIGNED (Month Day Year): September 6 1989

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): John S Kelly MD 2960 Highway 41 3 Highland In 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: E. A. Campagna M.D.

32 DATE FILED (Month Day Year): 9-7-89

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): APR 1 1993

34f LOCATION (Street and Number or Rural Route Number City or Town State): 00003

34g DATE PRONOUNCED DEAD (Month Day Year):

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

Anna R. Antosz
AUDITOR LAKE COUNTY

6.00

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1