1 93024439

2001

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No: 0562-93 .... 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)	ERLINDA FIERRO
2. SEX	FEMALE
3a. TIME OF DEATH	6:55 A.M.
3b. DATE OF DEATH (Month Day Yr)	MARCH 12, 1993
4. SOCIAL SECURITY NUMBER	354-24-9676
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)	APRIL 10, 1930
7. BIRTHPLACE (City and State or Foreign Country)	EAST CHICAGO, INDIANA
8a. WAS DECEDENT A US VETERAN?	NO
8b. YEAR LAST SERVED IN US ARMED FORCES?	N/A
9a. 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. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH	HOBART
9d. COUNTY OF DEATH	LAKE COUNTY
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife give maiden name)	JOSE FIERRO
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	N/A
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	PORTER
13c. CITY, TOWN OR LOCATION	PORTAGE
13d. STREET AND NUMBER	3200 HICKORY STREET
13e. ZIP CODE	46368
13f. INSIDE CITY LIMITS	[ ] No [XX] Yes
13g. ON A FARM?	[XX] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	[ ] No [XX] Yes — MEXICAN
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last)	MIGUEL TORRES
19. MOTHER'S NAME (First Middle Maiden Surname)	RAFAELA POMPA

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	JOSE FIERRO
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3200 HICKORY ST. PORTAGE, IN 46368
20c. Relationship	HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION	[XX] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	MARCH 15, 1993 CALVARY CEMETERY
21c. LOCATION—City or Town, State	PORTAGE, INDIANA
22a. EMBALMER'S NAME	JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO	FD01006463
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	David C. Mayer
24b. LICENSE NUMBER (of Licensee)	FD01012048
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	FH83005611 REES FUNERAL HOME, INC. OLSON CHAPEL 5341 CENTRAL AVE, PORTAGE, IN 46368

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. cardio pulmonary arrest
- DUE TO (OR AS A CONSEQUENCE OF): b. congestive heart failure
- DUE TO (OR AS A CONSEQUENCE OF): c. End Stage Renal failure
- DUE TO (OR AS A CONSEQUENCE OF): d.

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 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)	N/A

CERTIFIER

29a. CERTIFIER (Check only one)
- [XX] 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	K. Umapathy
29c. MEDICAL LICENSE NO	IN01036576
29d. DATE SIGNED (Month Day Year)	3/17/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Kupusamy Umapathy, M.D. 4802 BROADWAY, GARY, IN 46408

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	[signature], MD
32. DATE FILED (Month Day Year)	March 18, 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.	

01031 602

RECEIVED MARCH 1993 (LAKE COUNTY AUDITOR)

STATE OF INDIANA S.S. NO. ... LAKE COUNTY FILED FOR RECORD

THIS CERTIFIES THE ABOVE IS A TRUE COPY OF THE DEATH CERTIFICATE ON FILE WITH THE LAKE COUNTY ...

MAR 18 1993

FILED APR 15 1993

[signature] AUDITOR LAKE COUNTY

[signature] LAKE COUNTY HEALTH COMMISSIONER

#44-116-19 G. Land Co Lot S 1/2 Lt 23 Blk 116

State Form 10110 (R3 / 3-92)