93045756

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0853-93

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)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Josephine M. Mark	Female	2:15a.m	April 21, 1993

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
309-14-9618	73			Oct. 4, 1919	GAry, Indiana

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
No		HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Anthony's Hospital	Crown Point	Lake

10 MARITAL STATUS (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
Married	Peter Mark	Housewife	

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Crown Point	932 C. Monterrey Ct.

13e ZIP CODE	13f INSIDE CITY LIMITS?	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46307	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes, specify Cuban)	White	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Pasquale Malizia	Mary Pastore

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Peter Mark	932 C. Monterrey Ct. Crown Point, Ind.	Husband

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	April 24, 1993 Hebron Cemetery	Hebron, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
Anthony S. Rendina Jr.	FD01010402	☐ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Anthony S Rendina	FD01010402	Rendina F. Home FH 8300781 5100 Cleveland St. Gary, In 46408

CAUSE OF DEATH

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. Enter only one cause on each line.

THIS CERTIFIES THE ABOVE IS A TRUE, CORRECT AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.

		Approximate Interval Between Onset and Death
a. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Metastatic Small cell Pulmonary CA	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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

APR 29 1993

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Bernelo S. Green	0103930	4/22/93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

1112 S. Main St. Crown Point, IN 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE

32 DATE FILED (Month, Day, Year)

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c [illegible] or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

FILED
JUL 15 1993
AUDITOR LAKE COUNTY
00540

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

1/15/93 Edgewood Commons Maplewood (Bldg #1) Apt C (a condominium) 9-434-3