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Gerald KRAY

8721 Kennedy Highland 46322

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1181-92

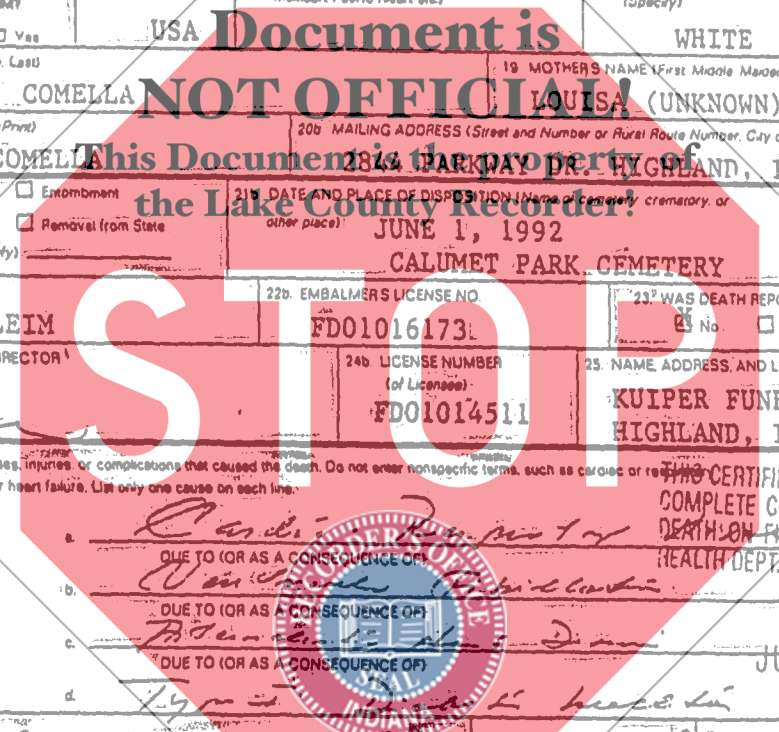
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First Middle Last) PHILIP E. COMELLA		2. SEX MALE	3a. TIME OF DEATH 3:00P	3b. DATE OF DEATH (Month Day Yr) MAY 30, 1992	
4. SOCIAL SECURITY NUMBER 181-12-1030	5a. AGE—Last Birthday (Years) 69	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) July 18, 1922	
7. BIRTHPLACE (City and State or Foreign Country) Butler, Pennsylvania	8a. WAS DECEDENT A US VETERAN? YES	8b. YEAR LAST SERVED IN US ARMED FORCES? 1945	9a. PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input checked="" type="checkbox"/> KK Hospital <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OGA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) ROSETTA RUFFINI	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). LABORER		12b. KIND OF BUSINESS/INDUSTRY LOCAL 41	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION HIGHLAND	13d. STREET AND NUMBER 2844 PARKWAY DR.		
13e. ZIP CODE 46322	13f. INSIDE CITY LIMITS? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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): 8 College (1-4 or 5+):		18. FATHER'S NAME (First Middle Last) (UNKNOWN) COMELLA			
19. MOTHER'S NAME (First Middle Maiden Surname) LOUISA (UNKNOWN)		20a. INFORMANT'S NAME (Type/Print) ROSETTA COMELLA			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2844 PARKWAY DR., HIGHLAND, INDIANA 46322		20c. Relationship to Decedent WIFE			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) JUNE 1, 1992 CALUMET PARK CEMETERY		21c. LOCATION—City or Town, State MERRILLVILLE, INDIANA	
22a. EMBALMER'S NAME EDGAR C. GLEIM		22b. EMBALMER'S LICENSE NO. FD010161731		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD01014511		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME KUIPER FUNERAL HOME 9039 KLEINMAN RD. HIGHLAND, INDIANA 46322 FH83007500	
26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or renal arrest, shock, or heart failure. Use only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Cardiac arrest</i> a. DUE TO (OR AS A CONSEQUENCE OF) <i>Coronary artery disease</i> b. DUE TO (OR AS A CONSEQUENCE OF) <i>Arteriosclerosis</i> c. DUE TO (OR AS A CONSEQUENCE OF) <i>Hypertension</i> d. <i>Myocardial infarction</i> PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		THE CERTIFIER THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. JUL 13 1993			
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO DETERMINATION OF CAUSE OF DEATH? (Yes or no) NO			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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: <i>[Signature]</i>			
29c. MEDICAL LICENSE NO. 19325		29d. DATE SIGNED (Month Day, Year) JUNE 1, 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) CARLOS A. SERNA, M.D. 2362 RIDGE ROAD HIGHLAND, INDIANA 46322					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Serna, M.D.</i>		32. DATE FILED (Month Day, Year) June 1, 1992			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) NO	34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, 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			

7/16/93 Dy
27-221-67
Lincoln Parkway Sub. E. 26ft-674 N. 32nd St. 66



FILED
JUL 16 1992
ALAN N. [Signature]

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