93054943

Local No. 93-0600

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ..H.i.g.h.l.a.n.d....4.7.3.2.2

Olivia P. Rivera
3100 - 45th AVE
Highland, In

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Maria Ramirez
2. SEX: Female
3a. TIME OF DEATH: 7:00 a.m.
3b. DATE OF DEATH (Month, Day, Yr.): August 5, 1993
4. SOCIAL SECURITY NUMBER: 308 32 4474
5a. AGE—Last Birthday (Years): 84
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): October 28, 1908
7. BIRTHPLACE (City and State or Foreign Country): Puerto Rico
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. 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): 4816 Jackson ST.
9c. CITY, TOWN OR LOCATION OF DEATH: Gary Indiana
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Julio Ramirez
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: Home Owner
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 4816 Jackson St.
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: ☐ No ☐ Yes
13g. ON A FARM: ☐ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): Puerto Rican
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): Facundo Rivero Sanchez
19. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Guilles

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Julio Ramirez
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4816 Jackson St. Gary IN. 46408
20c. Relationship: Husband

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): August 7, 1993 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville IN. 46410
22a. EMBALMER'S NAME: Anthony S. RendinaJr
22b. EMBALMER'S LICENSE NO.: FD01010402
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S Rendina Jr
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina Funeral Home FH83007819, 5100 Cleveland Gary, IN 46408

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Vascular collapse
DUE TO (OR AS A CONSEQUENCE OF):
b. Due to arteriosclerotic heart and vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death: Unknown

RECORDER'S OFFICE SEAL INDIANA

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 ☐ HEALTH OFFICER ☒ CORONER
To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. 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. 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.
Chief Investigator
29b. SIGNATURE AND TITLE OF CERTIFIER: William C Huber
29c. MEDICAL LICENSE NO: N/A
29d. DATE SIGNED (Month, Day, Year): August 6, 1993
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): William C. Huber, Chief Investigator, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): AUG 10 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 Ooccurred:
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): August 5, 1993
34h. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes, specify driver, passenger, etc.:

FILED
AUG 20 1993
Vera M. Anton
AUDITOR LAKE COUNTY

01365

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

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE AUG. 10 1993