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JOANN M. FLORIOS

93084072

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 3755-92 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): MARY R. EVANOFF	2. SEX: Female	3a. TIME OF DEATH: 5:00 P.M.	3b. DATE OF DEATH (Month Day Yr): December 30, 1992	
4. SOCIAL SECURITY NUMBER: 317-20-5270	5a. AGE—Last Birthday (Years): 78	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo Day Yr): August 13, 1914
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana	8a. WAS DECEDENT A U.S. VETERAN?: No	8b. YEAR LAST SERVED IN US ARMED FORCES?: --	9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)	
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		
10. MARITAL STATUS (Specify): Widowed	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): Sorter	12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel Corp.	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN OR LOCATION: Hobart	13d. STREET AND NUMBER: 5701 S. Liverpool Road	
13e. ZIP CODE: 46342	13f. INSIDE CITY LIMITS: [ ] No [X] Yes; 13g. ON A FARM?: [X] No [ ] Yes	14. CITIZEN OF WHAT COUNTRY?: USA	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): 08; College (1-4 or 5+): --				

PARENTS

18. FATHER'S NAME (First Middle Last): Michael Sandala

19. MOTHER'S NAME (First Middle Maiden Surname): Mary Spltis

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Joann Florios

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5701 S. Liverpool Rd. Hobart, Ind 46342

20c. Relationship: Daughter

DISPOSITION

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

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 2, 1993 Chapel Lawn Memorial Gardens

21c. LOCATION—City or Town, State: Schererville, Indiana

22a. EMBALMER'S NAME: Dean G. Wagner

22b. EMBALMER'S LICENSE NO: 8800057

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

24a. SIGNATURE OF FUNERAL DIRECTOR: John [signature]

24b. LICENSE NUMBER (of Licensee): FD# 1007321

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3002453 PRUZIN BROTHERS FUNERAL SERVICE 6360 Broadway, Merrillville, Ind. 46410

CAUSE OF DEATH

THIS CERTIFIES THAT ... COMPLETE COPY ... DEATH ON FILE WITH THE ...

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. acute left massive cerebellar infarction	12/26/93
DUE TO (OR AS A CONSEQUENCE OF)	b. Hypertension [illegible] Ischemic Heart Disease	
DUE TO (OR AS A CONSEQUENCE OF)	c. aortic stenosis (Severe)	12/29/93
DUE TO (OR AS A CONSEQUENCE OF)	d.	

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

1993

PART II. Other significant conditions—Conditions contributing to death but not previously related in Part I.

Alexander [signature]

LAKE COUNTY HEALTH COMMISSIONER

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: Richard J. Prucell M.D. [signature]

29c. MEDICAL LICENSE NO: 0101614B

29d. DATE SIGNED (Month, Day, Year): 1/4/93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Richard J. Prucell M.D., 109 East Lake, Griffith, Indiana 46319

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander [signature] M.D.

32. DATE FILED (Month, Day, Year): January 5, 1993

FILED

DEC 13 1993

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined

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.

Dennis M. Antich [signature]

9-902 6.00

12/13/93 [initials]

Key 117-34-11 117-34-11 117-209-117

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