

94023734

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 3015-93

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

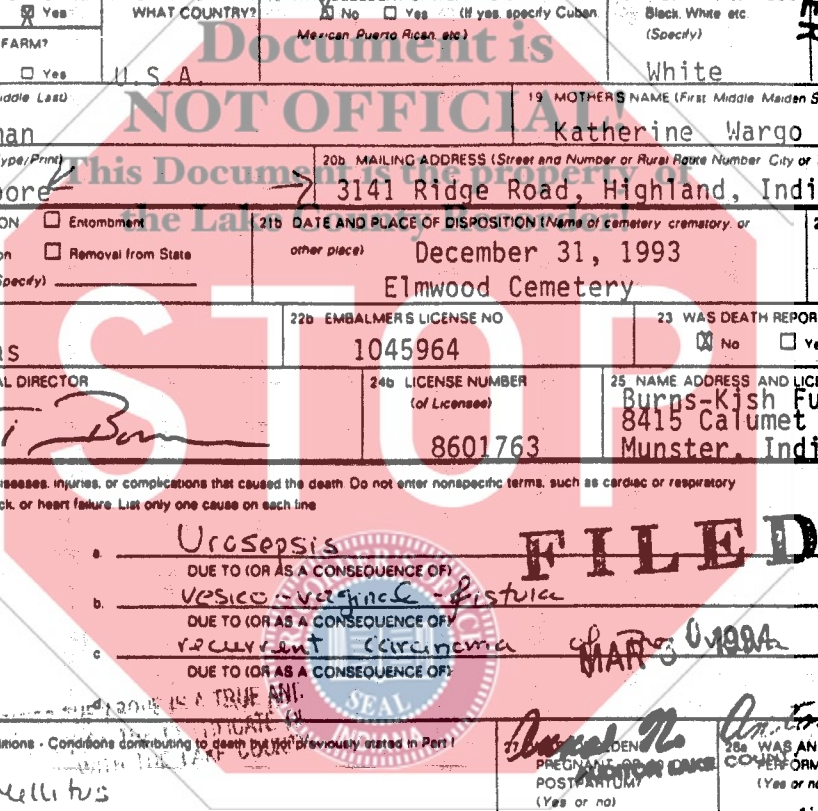
CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First, Middle, Last) HELEN MOORE		2 SEX FEMALE		3a TIME OF DEATH 1:15 P.M.		3b DATE OF DEATH (Month, Day, Year) DECEMBER 29, 1993	
4 SOCIAL SECURITY NUMBER 307 70 0804		5a AGE—Last Birthday (Years) 88		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) March 4, 1905		7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? none		9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ROA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 1324 Ridge Road				9c CITY/TOWN OR LOCATION OF DEATH Munster		9d COUNTY OF DEATH SL Lake	
10 MARITAL STATUS (Specify) Widowed		11 SURVIVING SPOUSE (If wife, give maiden name) none		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker			
12b KIND OF BUSINESS/INDUSTRY Own Home		13 STATE OF INDIANA FILED					
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY/TOWN OR LOCATION Munster		13d STREET AND NUMBER 1324 Ridge Road	
13e ZIP CODE 46321		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, American, Puerto Rican, etc.)	
16 RACE—American, Indian, Black, White, etc. (Specify) White		18 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary Secondary (0-12) <input type="checkbox"/> College (11-4 or 5) <input type="checkbox"/> Graduate <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> 8					
18 FATHER'S NAME (First, Middle, Last) George Girman				19 MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Wargo			
20a INFORMANT'S NAME (Type, Print) J. Roger Moore				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3141 Ridge Road, Highland, Indiana		20c Relationship Son	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) December 31, 1993 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Ind.			
22a EMBALMER'S NAME James Porras		22b EMBALMER'S LICENSE NO. 1045964		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 License) 8601763		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burbs-Kish Funeral Home #3004968 8415 Calumet Ave Munster, Indiana 46321			
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. Urosepsis				Approximate Interval Between Onset and Death 4 days	
		b. vesico-vaginal fistula				2 months	
		c. recurrent carcinoma of MATH. OVARY				1 year	
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Diabetes Mellitus							
27a WAS AN AUTOPSY PERFORMED? (Yes or no) NO		27b WAS AN AUTOPSY COVERED? (Yes or no) NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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. 40122		29d DATE SIGNED (Month, Day, Year) DECEMBER 30, 1993	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) DR. ANDREJ J. ZAJAC, M. D. 901 MACARTHUR BLVD. MUNSTER, INDIANA 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>						32 DATE FILED (Month, Day, Year) January 4, 1994	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> 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.			

621-81-149 #28



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