

94025972

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1210-92

Elizabeth M. Sotak
51 Carnation St
Dyer, IN 46311

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Elizabeth V. Sotak		2 SEX Female	3a TIME OF DEATH 11:06 P.M.	3b DATE OF DEATH (Month, Day, Year) June 2, 1992	
4 SOCIAL SECURITY NUMBER 347-58-5102	5a AGE—Last Birthday (Years) 94	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Feb. 12, 1898	
7 BIRTHPLACE (City and State or Foreign Country) Hungary	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"/> Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution give street and number) 51 Carnation St.		9c CITY TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife give maiden name) None	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker	12b KIND OF BUSINESS/INDUSTRY At Home		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Dyer	13d STREET AND NUMBER 51 Carnation St.		
13e ZIP CODE 46311	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input 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) <input checked="" type="checkbox"/> 8 College (1-4 or 5+) <input checked="" type="checkbox"/> 0		18 FATHER'S NAME (First Middle Last) Joe Gyula		
19 MOTHER'S NAME (First Middle Maiden Surname) Suzanna Nagy		20a INFORMANT'S NAME (Type/print) Elizabeth M. Sotak			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 51 Carnation St. Dyer, Indiana 46322		20c Relationship Daughter			
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) June 5, 1992 Holy Cross Cemetery		21c LOCATION (City or Town, State) Calumet City, Illinois	
22a EMBALMER'S NAME Lawrence Miller		22b EMBALMER'S LICENSE NO. FDE1006015		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR Lawrence Miller		24b LICENSE NUMBER (of Licensee) FDE1006015		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens for Roseport E.H. Lansing, Ill. 1920 Hart St. Dyer, Indiana 46311 FHR3001504	
26 PART I Enter the disease, 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) Cancer of the Liver DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)		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 COLLECTION 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 [Signature]			
29c MEDICAL LICENSE NO. 306E		29d DATE SIGNED (Month, Day, Year) June 9, 1992			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/print) JEROME E. MARCH D.O. 200 MONTICELLO DR., DYER, IN 46311					
31 HEALTH OFFICER'S SIGNATURE Alexander Williams MD		32 DATE FILED (Month, Day, Year) June 9, 1992			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			

PARENTS
INFORMANT

DISPOSITION

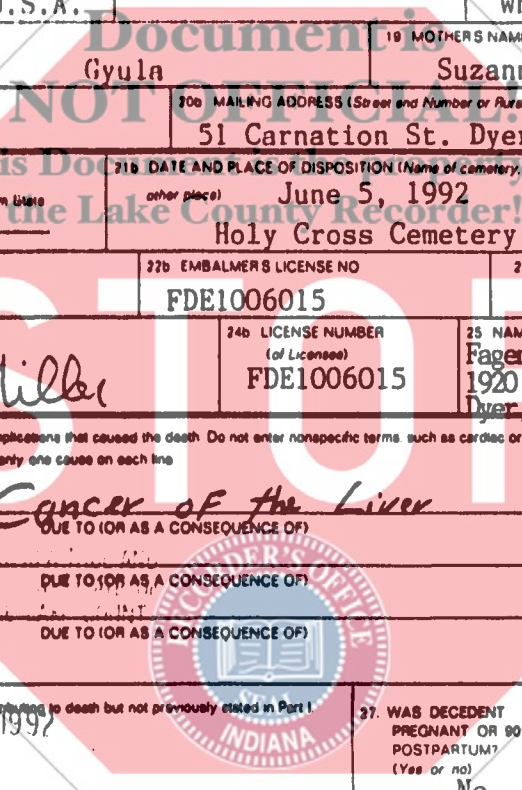
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

Howler Gardens Add.
A lot 22
14-105-22



FILED

APR 7 1994

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