6 c c

HOLD FOR:
THE TITLE SEARCH CO.

Local No. 308-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Virginia L. Saksa
2. SEX: Female
3a. TIME OF DEATH: 5:37 a.m.
3b. DATE OF DEATH (Month, Day, Yr.): January 7, 1990
4. SOCIAL SECURITY NUMBER: 312-34-2501
5a. AGE—Last Birthday (Years): 54
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): Oct. 5, 1935
7. BIRTHPLACE (City and State or Foreign Country): Porter, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: N/A
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [X] Residence
9b. FACILITY NAME (If not institution, give street and number): Broadway Methodist Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Robert J. Saksa
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: Family Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Cedar Lake
13d. STREET AND NUMBER: 11602 Parrish Avenue
13e. ZIP CODE: 46303
13f. INSIDE CITY LIMITS: [X] No [ ] 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): 12; College (1-4 or 5+): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): Vernie Babcock
19. MOTHER'S NAME (First, Middle, Maiden Surname): Beth Hutchens

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Robert J. Saksa
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11602 Parrish Ave., Cedar LK, IN 46303
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 9, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: William E. Burdan
22b. EMBALMER'S LICENSE NO.: FD01007697
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William E. Burdan
24b. LICENSE NUMBER (of Licensee): FD01007697
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: BURDAN FUNERAL HOME FH83002461, 12901 Wicker Ave., Cedar LK, IN 46303

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Metastatic Breast Cancer	1 year
DUE TO (OR AS A CONSEQUENCE OF)	b.	
DUE TO (OR AS A CONSEQUENCE OF)	c.	
DUE TO (OR AS A CONSEQUENCE OF)	d.	

PART II. Other significant conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPARTMENT

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
94 APR 28 PM 12:06
SAMUEL J. ROLICH RECORDER

CERTIFIER

29a. CERTIFIER (Check only one): [X] MEDICAL EXAMINER 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

LAKE COUNTY HEALTH COMMISSIONER

29b. SIGNATURE AND TITLE OF CERTIFIER: Mary J. Klein MD
29c. MEDICAL LICENSE NO.: 01034294
29d. DATE SIGNED (Month, Day, Year): January 24, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARY J KLEIN MD 1190 NORTH STATE RD 49 PORTER IND 46304

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Charles Johnson MD
32. DATE FILED (Month, Day, Year): Jan. 31, 1990

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 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.