ATTENTION ESTATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 0021-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. Lake Station 46405

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Mary Imbor
2. SEX: Female
3a. TIME OF DEATH: 3:30A M
3b. DATE OF DEATH (Month, Day, Yr.): January 1, 1995
4. SOCIAL SECURITY NUMBER: 305-12-9369
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): March 25,1917
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, IN.
8a. WAS DECEDENT A US VETERAN? No
8b. YEAR LAST SERVED IN US ARMED FORCES? ---
9a. PLACE OF DEATH (Check only one. See instructions): ☐ Hospital ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ Other ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 2700 Marion Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Lake Station
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): Clerk
12b. KIND OF BUSINESS/INDUSTRY: Grocery Store
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 713 West 151st Street
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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) / College or

PARENTS

18. FATHER'S NAME (First, Middle, Last): Stanley Kreczmer
19. MOTHER'S NAME (First, Middle, Maiden, Surname): Catherine Cak

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Carol O'Connell
20b. MAILING ADDRESS (Street and Number or R.F.D. Number, City or Town, State, Zip Code): 2700 Marion, Lake Station, IN 46405
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 7, 1995 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City, Ill.
22a. EMBALMER'S NAME: James W. Gholston
22b. EMBALMER'S LICENSE NO: 1004194
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John B. Leniak
24b. LICENSE NUMBER (of Licensee): 1005491
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Leniak FH83001601 4918 Magoun, E.Chicago, IN46312

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. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic Heart 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: 19 JAN 26 PM 12:25

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

27. WAS DECEDENT PREGNANT OR IN THE 90 DAYS PRECEDING DEATH? (Yes or No): No
28. IF FEMALE AND NOT PREGNANT, WAS PREGNANCY A CONTRIBUTING CAUSE OF DEATH? (Yes or no): No

CERTIFIER

29a. CERTIFIER (Check only one): ☐ PERSONALLY ATTENDED 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.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ronald Feldner
29c. MEDICAL LICENSE NO: 019183
29d. DATE SIGNED (Month, Day, Year): 1/4/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29) (Type/Print): Ron Feldner, 7905 Calumet Avenue, Munster, IN. 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D
32. DATE FILED (Month, Day, Year): January 5, 1995
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.

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1