

196-36-508-9

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
MAR. 11, 1992
Date Issued
Hammond Health Commissioner

Local No. 205

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

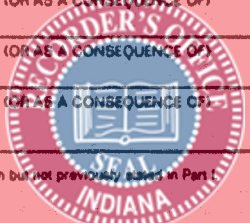
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First, Middle, Last) Armourelida V. Sabo		2 SEX Female	3a TIME OF DEATH 10:40P	3b DATE OF DEATH (Month, Day, Year) March 9, 1992
4 SOCIAL SECURITY NUMBER 316-14-9186		5a AGE—Last Birthday (Year) 67	5b UNDER 1 YEAR Months Days March 17, 1925	5c UNDER 1 DAY Hours Minutes 17, 1925
6 DATE OF BIRTH (Mo., Day, Yr) JAN 17, 1925		7 BIRTHPLACE (City and State or Foreign Country) New Castle, Pennsylvania		
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) 7621 Grand Avenue		9b CITY, TOWN OR LOCATION OF DEATH Hammond	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) George Sabo	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Executive Director	12b KIND OF BUSINESS/INDUSTRY Home Nursing Service	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 7621 Grand Avenue	
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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 10-12—College (1-4 or 5+) 12		18 FATHER'S NAME (First, Middle, Last) William C. Hammond		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Mildred		20a INFORMANT'S NAME (Type/Print) George Sabo		
20b MARITAL STATUS (Type/Print) Husband		20c ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7621 Grand Ave., Hammond, IN 46323		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) Chapel Lawn Memorial Gardens		21c LOCATION—City or Town Schererville, Indiana
22a EMBALMER'S NAME Charles D. Scheuer Jr.		22b EMBALMER'S LICENSE NO. 1006049	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer Jr.</i>		24b LICENSE NUMBER (of Licensee) 1006049	24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323	
25 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) metastatic carcinoma of the lung DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST a. _____ b. _____ c. _____ d. _____		PART II Other significant conditions - Conditions contributing to death but not previously listed in Part I		
26a 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.		27 WAS DEATH INVESTIGATION SUBJECT TO PUBLIC HEALTH NOTIFICATION? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
28b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		28c MEDICAL LICENSE NO. 1036259	28d DATE SIGNED (Month, Day, Year) March 11, 1992	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John H. Gleaton M.D., 7905 Calumet Avenue, Ellettsville, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) March 11, 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"/> 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 PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e 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.		



ONLY ENTERED FOR NOTIFICATION SUBJECT TO PUBLIC HEALTH NOTIFICATION FOR TRANSFER

FINAL ACCEPTANCE FOR TRANSFER

JUN 5 1995

SAMUEL L. LAKE COUNTY AUDITOR

MAILED 9550H-5 PM 21

RECEIVED

STATE OF INDIANA LAKE COUNTY RECORDER FOR RECORD

136-508-9

17-89-A

600

Hold: Lynne CREA - 3760