1, 26-36-508-9

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAR. 11, 1992 — Date Issued — Franklin [signature] — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 205

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	Armourelda V. Sabo
2. Sex	Female
3a. Time of Death	10:40P M
3b. Date of Death (Month Day Yr)	March 9, 1992
4. Social Security Number	316-14-9186
5a. Age—Last Birthday (Years)	67
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo. Day, Yr)	JAN 17, 1925
7. Birthplace (City and State or Foreign Country)	New Castle, Pennsylvani
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	7621 Grand Avenue
9c. City, Town, or Location of Death	Hammond
9d. 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	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	William C. Hammond
19. Mother's Name (First, Middle, Maiden Surname)	Mildred Lowers

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	George Sabo
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7621 Grand Ave., Hammond, IN 46323
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	March 12, 1992 Chapel Lawn Memorial Gardens
21c. Location—City or Town, State	Schererville, Indiana
22a. Embalmer's Name	Charles D. Scheuer Jr.
22b. Embalmer's License No.	1006049
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	1006049
25. Name, Address, and License Number of Funeral Home	3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323

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.

	Cause	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	metastic carcinoma of the lung	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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

Field	Entry
27. Was Decedent Pregnant ... Days	No
28a. Was an Autopsy Performed? (Yes or no)	No
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)	N

CERTIFIER

29a. Certifier (Check only one)
- ☒ CERTIFYING PHYSICIAN 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.

Field	Entry
29b. Signature and Title of Certifier	[signature]
29c. Medical License No.	01036259
29d. 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, Munster, Indiana 46321

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Franklin [signature]
32. Date Filed (Month, Day, Year)	March 11, 19[..]

CORONER USE ONLY

Field	Entry
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.	

17-89-A

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD I

Hold: Lynne McCrea — 3760

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136-508-9

950 30506

FILED FOR RECORD LAKE COUNTY STATE OF INDIANA 95 JUN -5 PM 2: MARGARET ... RECORDER

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER JUN 5 1995 SAM ORLICH AUDITOR LAKE COUNTY

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