JCC 60485

PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS DOCUMENT NOT VALID
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CEDENT

RENTS

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POSITION

USE OF ATH

RTIFIER

ALTH ICER

RONER ONLY

1 DECEASED—NAME (First, Middle, Last): LOUISE A VUKO			2 SEX: FEMALE	3a TIME OF DEATH: 4:45 p M	3b DATE OF DEATH (Month, Day, Yr.): MARCH 29,1990
4 SOCIAL SECURITY NUMBER: 312-05-9525	5a AGE—Last Birthday (Years): 73	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr.): JULY 25, 1916	7 BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a WAS DECEDENT A U.S. VETERAN?: NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES?: NO	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence			
9b FACILITY NAME (If not institution, give street and number): FOUNTAINVIEW NURSING HOME		9c CITY, TOWN, OR LOCATION OF DEATH: PORTAGE		9d COUNTY OF DEATH: PORTER	
10 MARITAL STATUS (Specify): MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name): JOHN VUKO	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): BEAUTICIAN		12b KIND OF BUSINESS/INDUSTRY: HAIR SALON	
13a RESIDENCE—STATE: INDIANA	13b COUNTY: LAKE	13c CITY, TOWN OR LOCATION: GARY, INDIANA		13d STREET AND NUMBER: 4864 WASHINGTON STREET	
13e ZIP CODE: 46408	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): 12; College (1-4 or 5+):
	13g ON A FARM? ☒ No ☐ Yes				
18 FATHER'S NAME (First, Middle, Last): ERNEST T PETERSON		19 MOTHER'S NAME (First, Middle, Maiden Surname): ANNA CARLSON			
20a INFORMANT'S NAME (Type/Print): JOHN VUKO		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4864 WASHINGTON ST. GARY, IN 46408		20c Relationship: HUSBAND	
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): APRIL 2, 1990 CHAPEL LAWN MEMORIAL GARDENS		21c LOCATION—City or Town, State: SCHERERVILLE, INDIANA	
22a EMBALMER'S NAME: GORDON L JONES		22b EMBALMER'S LICENSE NO.: 0010710		23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	
24a SIGNATURE OF FUNERAL DIRECTOR: Terrence L. Burns		24b LICENSE NUMBER (of Licensee): 1013890		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME, 10101 BROADWAY, CROWN POINT, IN 46307-8600018	

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter terminal events 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 Cardiopulmonary arrest	minutes
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): b Cerebral vascular accident	weeks
	DUE TO (OR AS A CONSEQUENCE OF): c [illegible]	years
	DUE TO (OR AS A CONSEQUENCE OF): d	

PART II. Other significant conditions - 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)
NO	NO	NO

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.

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Jack H Ziegler	031712	4-6-90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JACK H. ZIEGLER, MD, 8909 BROADWAY, MERRILLVILLE, INDIANA 46410

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Jay N. Rabuchin MD	April 9 1990

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				
	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.			

000261

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
1990 NOV 26 PM 10:09
MARGARET BYNUM RECORDER

SAM ORLICH
PORTER COUNTY
AUDITOR