6 ccs

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1373-94 State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	LUCILLE PETRITES
2. SEX	Female
3a. TIME OF DEATH	8:50 PM
3b. DATE OF DEATH (Month, Day, Yr)	June 19, 1994
4. SOCIAL SECURITY NUMBER	317-20-8650
5a. AGE—Last Birthday (Years)	66
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	May 13, 1928
7. BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	--
9a. PLACE OF DEATH (Check only one)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME	Methodist Hospital - Southlake Campus
9c. CITY, TOWN, OR LOCATION OF DEATH	Merrillville
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Frank Petrites
12a. DECEDENT'S USUAL OCCUPATION	Homemaker
12b. KIND OF BUSINESS/INDUSTRY	Own Home
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Merrillville
13d. STREET AND NUMBER	5511 Tyler Street
13e. ZIP CODE	46410
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?	[X] No [ ] Yes
16. RACE	White
17. DECEDENT'S EDUCATION (Elementary/Secondary (0-12), College (1-4 or 5+))	12

PARENTS

Field	Entry
18. FATHER'S NAME	Joseph Plisousky
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Petre Jarocka

INFORMANT

Field	Entry
20a. INFORMANT'S NAME	Frank Petrites
20b. MAILING ADDRESS	5511 Tyler St., Merrillville, IN 46410
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION	June 23, 1994 Calvary Cemetery
21c. LOCATION—City or Town, State	Portage, Indiana
22a. EMBALMER'S NAME	Charles W. Wells
22b. EMBALMER'S LICENSE NO.	1042372
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death.

IMMEDIATE CAUSE: Metastatic Cancer of Ovary — Approximate Interval Between Onset and Death: 18 Months

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions: Delayed Transfusion Reaction, Massive Lower Intestinal Bleed

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM?	No
28a. WAS AN AUTOPSY PERFORMED?	No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	

CERTIFIER

29a. CERTIFIER (Check only one)
- [X] 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	Barbara L. Fuller, M.D.
29c. MEDICAL LICENSE NO.	01034701
29d. DATE SIGNED	6/21/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)	Barbara Fuller, M.D., 3229 Broadway, Gary, IN 46409 (219) 980-7160

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, M.D.
32. DATE FILED	June 21, 1994

Field	Entry
33. MANNER OF DEATH	[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a. DATE OF INJURY	
34b. TIME OF INJURY	
34c. INJURY AT WORK?	
34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY	
34f. LOCATION	
34g. DATE PRONOUNCED DEAD	
34h. MOTOR VEHICLE ACCIDENT?	

#15-281-29

9807230

900 SK CS

001547

SDH08-004 State Form 10110 (R4/3-93) Deathcer/PD 1

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 NOV 28 PM 2:33 MARGARET... RECORDER

THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT NOV 28 1995

Alexander S. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER

FILED NOV 28 1995 SAM ORLICH AUDITOR LAKE COUNTY

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