

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.

Local No. .... 521 .....

Jun. 12, 1992 Frank G. Penuel M.D.  
Date Issued Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) <b>Mary Joy Sersic</b>		2 SEX <b>Female</b>		3a TIME OF DEATH <b>7:05P.</b>		3b DATE OF DEATH (Month, Day, Year) <b>June 10, 1992</b>	
4 SOCIAL SECURITY NUMBER <b>316-36-5409</b>		5a AGE—Last Birthday (Year) <b>55</b>		5b UNDER 1 YEAR Months: Days:		5c UNDER 1 DAY Hours: Minutes:	
6 DATE OF BIRTH (Mo, Day, Yr) <b>APR 15, 1937</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>					
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) <b>St. Margaret Mercy Hospital</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>Hammond</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>High School Teacher</b>		12b KIND OF BUSINESS/INDUSTRY <b>Education</b>	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN OR LOCATION <b>Hammond</b>		13d STREET AND NUMBER <b>6910 Knickerbocker Parkway</b>	
13e ZIP CODE <b>46323</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify)		16 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>		17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (13-16 or 17+)			
18 FATHER'S NAME (First, Middle, Last) <b>Metro Bindas</b>				19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary D. Babyak</b>			
20a INFORMANT'S NAME (Type/Print) <b>Jack Sersic</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6910 Knickerbocker Parkway, Hammond, IN 46323</b>		20c Relationship <b>Husband</b>			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>JUN 15, 1992 St. John Cemetery</b>		21c LOCATION—City or Town, State <b>Hammond, Indiana</b>			
22a EMBALMERS NAME <b>Charles D. Scheuer Jr.</b>		22b EMBALMER'S LICENSE NO. <b>1006049</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer Jr.</i>		24b LICENSE NUMBER (of Licensee) <b>1006049</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323</b>			
26 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 on one line each cause on each line. <b>Adenocarcinoma of Gallbladder</b> <b>Local metastases of Adenocarcinoma</b>							
26 PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>Hypertension</b> <b>Ventricular Arrhythmia</b>							
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? <b>No</b>		28b WAS AN AUTOPSY FROM AVAILABLE TO COMPLETION OF CAUSE OF DEATH? <b>NO</b>			
29a 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) as stated.		29b SIGNATURE AND TITLE OF CERTIFIER <i>Christine M. Riley MD</i>		29c MEDICAL LICENSE NO. <b>01037464</b>		29d DATE SIGNED (Month, Day, Year) <b>June 12, 1992</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (EM 26) (Type/Print) <b>Christine M. Riley M.D., 2075 Indianapolis Blvd., Whiting, Indiana 46394</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Frank G. Penuel M.D.</i>						32 DATE FILED (Month, Day, Year) <b>June 12, 1992</b>	
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) <b>NOV 24 1988</b>		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 DESCRIBE HOW INJURY OCCURRED			
		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)					

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



Woodmar Unit #11  
Lot 13 & 14 Block 41  
Key # 36-421-15  
Unit # 26

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORDER  
JUN 12 1992  
9:00 PM  
REC'D

FILED

SAM ORLICH  
AUDITOR LAKE COUNTY

16885