

* 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

State No.....

Local No. 0768-94

5 Reg
2 Ver
Total

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) FRANK GEORGE MANDULA		2. SEX Male	3a. TIME OF DEATH 7:44AM	3b. DATE OF DEATH (Month Day Yr) April 14, 1996
4. SOCIAL SECURITY NUMBER 312-05-6778	5a. AGE - Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Feb 3, 1915
7a. WAS DECEDENT A U.S. VETERAN? Yes	7b. YEAR LAST SERVED IN U.S. ARMED FORCES 1944	7. BIRTHPLACE (City and State or Foreign Country) Gary, IN		
8a. FACILITY NAME (If not institution, give street and number) 2420 W. 49th Avenue		8b. CITY TOWN OR LOCATION OF DEATH Hobart		8c. COUNTY OF DEATH Lake
9. MARITAL STATUS (Specify) Widowed	10. SURVIVING SPOUSE (If wife, give maiden name) NONE	11. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Owner/Operator		12. KIND OF BUSINESS INDUSTRY Self-Employed
13a. RESIDENCE - STATE IN	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 2420 W. 49th Avenue	
13e. ZIP CODE 46342	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)		17. DECEDENT'S EDUCATION (Specify only highest grade completed)		
<input type="checkbox"/> Elementary/Secondary (0-12)		<input type="checkbox"/> College (1-4 or 5+)		
12		12		
18. FATHER'S NAME (First, Middle, Last) Joseph Mandula		19. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Palsa		
20a. INFORMANT'S NAME (Type/Print) Evelyn Lahaie		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 652 Water Street, Hobart, IN 46342		20c. Relationship Sister-in-law
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) Apr 16, 1996 Calumet Park Cemetery		21c. LOCATION - City or Town State Merrillville, IN
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FDO1006463	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342	
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 only one cause on each line.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE DEATH CERTIFICATE AS FILED IN THE PUBLIC RECORDS OF THE LAKE COUNTY HEALTH DEPT. vascular collapse Due to arteriosclerotic heart and vascular disease				
Conditions if any which gave rise to the immediate cause stating the underlying cause last APR 14 1996				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. LAKE COUNTY HEALTH COMMISSIONER				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) 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)
29a. CERTIFIER (Check only one) Deputy		<input 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 checked="" 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.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Evelyn Lahaie</i>		29c. MEDICAL LICENSE NO. N/A
29d. DATE SIGNED (Month Day Year) April 15, 1996		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307		
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>		32. DATE FILED (Month Day Year) April 15, 1996		
33. MANNER OF DEATH <input checked="" 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. DESCRIBE HOW INJURY OCCURRED APR 17 1996		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) AUDITOR LAKE COUNTY		34g. DATE PRONOUNCED DEAD (Month, Day, Year) April 14, 1996		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian		34i. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian		

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STATE OF INDIANA LAKE COUNTY PUBLIC RECORDS OFFICE
APR 17 1996 11:12 AM
RECORDED

Key # 17-348-31

FILED

SAM ORLICH
AUDITOR LAKE COUNTY

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