

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

1508 HOFFMAN ST
HAMMOND, IN 46327

Local No. 1531-95

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First Middle Last) Sophie K. Szot		2 SEX Female	3a TIME OF DEATH 1:00p M	3b DATE OF DEATH (Month Day, Yr) July 6, 1995
4 *SOCIAL SECURITY NUMBER 312-10-3581	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. 13, 1914
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, 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 See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) Meridian Nursing Center		9c CITY, TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife, give maiden name) -	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY Own Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Dyer		13d STREET AND NUMBER 601 Sheffield Avenue
13e ZIP CODE 46311	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? U.S.A.	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) Elementary/Secondary (0-12) College (1+ or 5+) 11		
18 FATHER'S NAME (First Middle Last) John Kabala		19 MOTHER'S NAME (First Middle Maiden Surname) Katherine Citara		
20a INFORMANT'S NAME (Type/Print) Frank R. Szot		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town State Zip Code) 1508 Hoffman St., Hammond, IN 46327		20c Relationship Son
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) July 10, 1995 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME James H. Fife		22b EMBALMER'S LICENSE NO. FD01010795		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>John F. Fife</i>		24b LICENSE NUMBER (of Licensee) FD01020366		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME - FH83001512 4201 Indpls. Blvd., Ellettsville, IN 47404
26 PART I Enter the disease, injuries or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory. List only one cause on each line. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Disease				
26 PART II Other significant conditions contributing to death but not previously stated in Part I None				
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) <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) and manner as stated.				
29b SIGNATURE AND TITLE OF CERTIFIER <i>Alan Jones DO</i>		29c MEDICAL LICENSE NO. 640		29d DATE SIGNED (Month, Day, Year) 7/10/95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Alan Jones, M.D. - 9128 Columbia Ave., Munster, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Alan Jones, M.D.</i>				32 DATE FILED (Month, Day, Year) July 10, 1995
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)	34b TIME OF INJURY	34c INJURY A WORK INJURY? FILED
34d PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) MAY 10 1996		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. SAM ORLICH		
AUDITOR LAKE COUNTY				000417