Local No. 627

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.

Oct 7, 1996 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Lillian N. Parker
2 SEX: Female
3a TIME OF DEATH: 3:22 am
3b DATE OF DEATH (Month Day Yr): July 25, 1990
4 SOCIAL SECURITY NUMBER: 345-05-2204
5a AGE—Last Birthday (Years): 69
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day, Yr): DEC 6, 1920
7 BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a WAS DECEDENT A US VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: NONE
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): ST. MARGARET HOSPITAL
9c CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d COUNTY OF DEATH: COOK
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): JAMES PARKER
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): OWNER
12b KIND OF BUSINESS/INDUSTRY: RESTAURANT
13a RESIDENCE—STATE: ILLINOIS
13b COUNTY: COOK
13c CITY, TOWN, OR LOCATION: CALUMET CITY
13d STREET AND NUMBER: 771 BUFFALO
13e ZIP CODE: 60409
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
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): 9; College (1-4 or 5+): 0

PARENTS

18 FATHER'S NAME (First, Middle, Last): SAMUEL ALEXOVICH
19 MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN RUDNECKIE

INFORMANT

20a INFORMANT'S NAME (Type/Print): JAMES PARKER
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 771 BUFFALO AV., CALUMET CITY, IL 60409
20c Relationship: HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JULY 28, 1990 ELMWOOD CEMETERY
21c LOCATION—City or Town, State: HAMMOND, INDIANA
22a EMBALMER'S NAME: LEO V. HENNESSY
22b EMBALMER'S LICENSE NO: IL #029-010388
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan
24b LICENSE NUMBER (of Licensee): 1051840
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: #FD02893 Solan F.H. 7109 Calumet AV Hammond, I for NOWAK FUNERAL HOME, CALUMET CITY,

CAUSE OF DEATH

26 PART I. Enter the diseases, 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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac Arrthymia (Cardiac Arrthymia)
DUE TO (OR AS A CONSEQUENCE OF):
b. End Stage Renal Disease (End Stage Renal Disease)
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions. Conditions contributing to death but not previously related in Part I.
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):

CERTIFIER

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.: 848
29d DATE SIGNED (Month, Day, Year): July 26, 1990
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. Mischel, D.O. 5454 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin J. Ormunda M.D.
32 DATE FILED (Month, Day, Year): JUL 26 1990

CORONER USE ONLY

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

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD I

FILED OCT 9 1996 SAM ORLICH AUDITOR LAKE COUNTY 000586

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 OCT -9 AM 9:08 MARGARET ... RECORDER

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