

Marie Zerza, 2682 La Porte St., Lake Station 46405

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 219-93

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

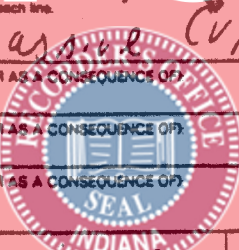
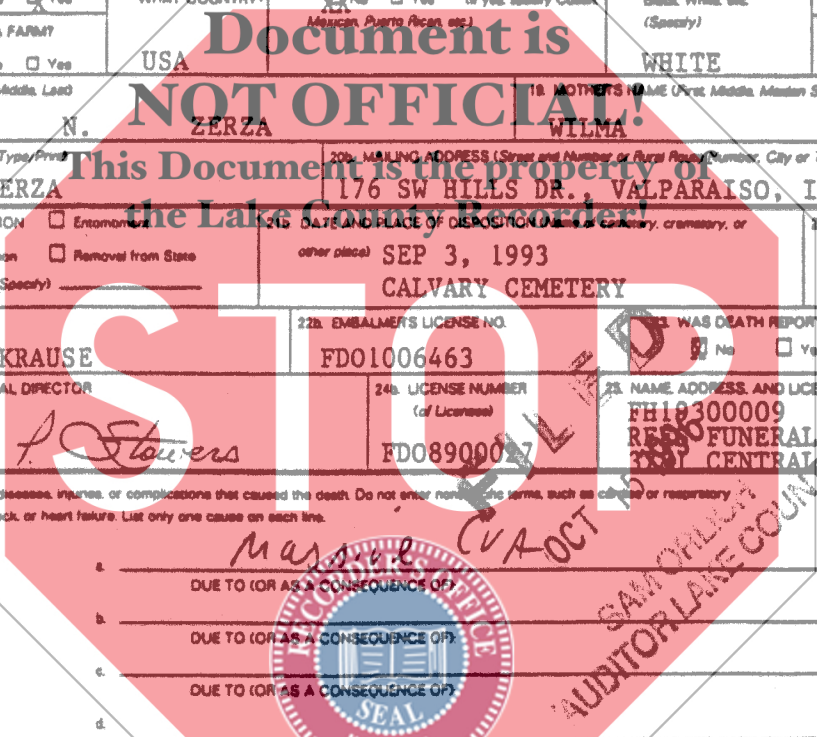
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) JOSEPH N. ZERZA SR.		2 SEX MALE	3a. TIME OF DEATH 10:00 AM	3b. DATE OF DEATH (Month, Day, Year) AUGUST 31, 1993
4 SOCIAL SECURITY NUMBER 303-24-7366	5a. AGE—Last Birthday (Years) 68	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) MARCH 10, 1925
7. BIRTHPLACE (City and State or Foreign Country) EAST GARY, INDIANA	8a. WAS DECEDENT A U.S. VETERAN? NO			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A		8c. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER		9b. CITY, TOWN, OR LOCATION OF DEATH HOBART	9c. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) MARIE PACIFIC	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SUPERVISOR		12b. KIND OF BUSINESS/INDUSTRY SCHOOL CITY OF GARY
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION LAKE STATION	13d. STREET AND NUMBER 2682 LAPORTE STREET	
13a. ZIP CODE 46405	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) Elementary/Secondary (0-12) 12		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (11-4 or 5+) 606899		
18. FATHER'S NAME (First, Middle, Last) JOSEPH N. ZERZA		18. MOTHER'S NAME (First, Middle, Maiden Surname) WILMA KOVACH		
20a. INFORMANT'S NAME (Type/Print) GARY J. ZERZA		20b. MAILING ADDRESS (Street and Number or Rural Route, Number, City or Town, State, Zip Code) 176 SW HILLS DR., VALPARAISO, IN 46383		20c. Relationship SON
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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 (Date, City, County, cemetery, or other place) SEP 3, 1993 CALVARY CEMETERY		21c. LOCATION—City or Town, State PORTAGE, INDIANA
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FDO1006463		22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Kenneth P. Stowers</i>		24b. LICENSE NUMBER (of Licensee) FDO89000		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH1930009 REPOSE FUNERAL HOME, BRADY CHAPEL AVE. LAKE STATION, IN.
26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter non-causal terms, such as cancer or respiratory arrest, shock, or heart failure. List only one cause on each line.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. _____ b. _____ c. _____ d. _____				
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Milton Gasparis</i>		29b. MEDICAL LICENSE NO. 01037515		29c. DATE SIGNED (Month, Day, Year) 02 Sept 93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MILTON GASPARIS MD, 1356 S. LAKE PARK AVE., HOBART, IN 46342				
31. HEALTH OFFICER'S SIGNATURE <i>Alvin Williams MD</i>				32. DATE FILED (Month, Day, Year) 2, 1993
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 AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route, City or Town, State) OCT 15 1993 60101		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <i>Alvin Williams, MD</i> LAKE COUNTY HEALTH COMMISSIONER		

#19-39-16, #20-9a-d3q24,25



RECORDED
OCT 15 AM 10:54
STATE OF INDIANA
LAKE COUNTY
REC'D FOR RECORD