Marie Zerza, 2682 LaPorte St., Lake Station 46405

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2112-93

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

Field	Entry
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, Yr)	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 (Mo, Day, Yr)	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
9a. Place of Death	HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. Facility Name (If not institution, give street and number)	ST. MARY MEDICAL CENTER
9c. City, Town, or Location of Death	HOBART
9d. 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
13e. Zip Code	46405
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	XX No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	WHITE
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5+)	

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	JOSEPH N. ZERZA
19. Mother's Name (First, Middle, Maiden Surname)	WILMA KOVACH

INFORMANT

Field	Entry
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

DISPOSITION

Field	Entry
21a. Method of Disposition	XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, 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.	FD01006463
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	Kenneth P. Stowers
24b. License Number (of Licensee)	FD08900027
25. Name, Address and License Number of Funeral Home	FH10300009 REES FUNERAL HOME, BRADY CHAPEL 3301 CENTRAL AVE., LAKE STATION, IN 46405

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter mode of dying, 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. Massive CVA
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
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 resulting in the underlying cause given in Part I

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	28a. Was an Autopsy Performed? (Yes or no)	28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)
N/A	NO	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.	29d. Date Signed (Month, Day, Year)
Milton Gasparis	01037515	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

HEALTH OFFICER

31. Health Officer's Signature	32. Date Filed (Month, Day, Year)
[signature] MD	September 2, 1993

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.

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

[signature], MD
LAKE COUNTY HEALTH COMMISSIONER

OCT 15 1996
C01017

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1

#19-39-16, #20-92-239 24, 25

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
OCT 15 AM 10:54
MORRIS W. CARTER / RECORDER

960 68993

FILED
OCT 15 1996
SAM ORLICH
AUDITOR LAKE COUNTY