LAKE COUNTY CERTIFIES THE FOLLOWING IS A TRUE AND
FILED FOR RECORD COPY OF DEATH ON FILE WITH THE
HAMMOND HEALTH DEPARTMENT

*ATTENTION ESTATE ... being requested by this state agency, in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1041

97009610 CERTIFICATE OF DEATH

97 FEB -6 PM 3:09

Date Issued — Commissioner of Health

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

MORRIS W. CARTER
RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ANDREW J. SUSORENY
2. SEX: MALE
3. DATE OF DEATH (Mo. Day Yr.): DECEMBER 22, 1996
4. SOCIAL SECURITY NUMBER: 313-50-5162
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo. Day Yr.): NOV. 12, 1913
7. BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
8a. WAS DECEDENT EVER IN U.S. ARMED FORCES?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify); XX Residence
9b. FACILITY NAME (If not institution, give street and number): 1413 LAKE AVENUE
9c. CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS: MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): JULIE BANKO
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: AMOCO OIL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HAMMOND (WHITING P.O.)
13d. STREET AND NUMBER: 1413 LAKE AVENUE
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS? ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN SUSORENY
19. MOTHER'S NAME (First, Middle, Maiden Surname): SUSAN ZIARA

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MRS. JULIE SUSORENY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1413 LAKE AVE., WHITING, IN 46394
20c. Relationship: WIFE

DISPOSITION

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): DECEMBER 27, 1996 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIA
22a. EMBALMER'S NAME: MARTIN A. DYBEL
22b. EMBALMER'S LICENSE NO.: FDE01019456
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Martin A. Dybel
24b. LICENSE NUMBER (of Licensee): FDL01019456
24c. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267, 1235-119TH ST., WHITING, IN 46

CAUSE OF DEATH

25. 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. RESPIRATORY INFECTION
DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY ARTERY DISEASE
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 previously stated in Part I: CONGESTIVE HEART FAILURE

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): N/A

FILED
FEB 6 1997
SAM ORLICH
AUDITOR LAKE COUNTY

CERTIFIER

29a. CERTIFIER (Check only one): XX 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: Miguel A. Gambetta
29c. MEDICAL LICENSE NO.: 25594
29d. DATE SIGNED (Month Day Year): DECEMBER 26, 1

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print): MIGUEL A. GAMBETTA, M.D., 4320 FIR, EAST CHICAGO, INDIANA 46312
31. HEALTH OFFICER'S SIGNATURE: Graciela L. Miranda M.D.
32. DATE FILED (Month Day Year): DEC 26 1996

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

#35-309-6-7-61

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1