"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

CERTIFICATE OF DEATH

Local No. 2369-95 State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First, Middle, Last): MARTHA RUTH PARA
- 2. SEX: FEMALE
- 3a. TIME OF DEATH: 7:20 AM
- 3b. DATE OF DEATH (Month, Day, Yr): OCTOBER 18, 1995
- 4. *SOCIAL SECURITY NUMBER: 280-20-6765
- 5a. AGE—Last Birthday (Years): 73
- 5b. UNDER 1 YEAR (Months, Days):
- 5c. UNDER 1 DAY (Hours, Minutes):
- 6. DATE OF BIRTH (Mo, Day, Yr): JUNE 13, 1922
- 7. BIRTHPLACE (City and State or Foreign Country): Youngstown, Ohio
- 8a. WAS DECEDENT A U.S. VETERAN? no
- 8b. YEAR LAST SERVED IN US ARMED FORCES? none
- 9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
- 9b. FACILITY NAME (If not institution, give street and number): Community Hospital
- 9c. CITY, TOWN OR LOCATION OF DEATH: Munster
- 9d. COUNTY OF DEATH: Lake
- 10. MARITAL STATUS (Specify): Widowed
- 11. SURVIVING SPOUSE (If wife, give maiden name): none
- 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: Hammond
- 13d. STREET AND NUMBER: 631-169th Street
- 13e. ZIP CODE: 46324
- 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): 12; College (1-4 or 5+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Paul Tomansula
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Marineak

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Mr. Raymond A. Para
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631-169th St. Hammond, IN 46324
- 20c. Relationship: Son

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): October 20, 1995 Elmwood Cemetery
- 21c. LOCATION—City or Town, State: Hammond, Indiana
- 22a. EMBALMER'S NAME: David McCoy
- 22b. EMBALMER'S LICENSE NO.: FDO8700581
- 23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
- 24b. LICENSE NUMBER (of Licensee): FDO1013507
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FH03002801 7042 Kennedy Ave. Hammond, IN 46323

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. Advanced Malignant lymphoma
- b. DUE TO (OR AS A CONSEQUENCE OF):
- c. DUE TO (OR AS A CONSEQUENCE OF):
- d. DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Azotemia, Diabetes Mellitus

- 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no
- 28a. WAS AUTOPSY PERFORMED? (Yes or no): no
- 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: [signature]
- 29c. MEDICAL LICENSE NO.: 25782
- 29d. DATE SIGNED (Month, Day, Year): Oct. 19, 1995
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M.Y. Ali, M.D., 1630 W. 45th Ave. Munster, IN 46321

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D.
- 32. DATE FILED (Month, Day, Year): October 19, 1995

- 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.

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

900 / 8H / CK# 158

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. OCT 19 1995 — LAKE COUNTY HEALTH COMMISSIONER

FILED APR 17 1997 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 97 APR 9 AM 11:25 MORRIS W. CARTER RECORDER

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