INDIANA STATE BOARD OF HEALTH

Local No. 1552-90

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): EMMA M. TUMIDALSKY
2. SEX: FEMALE
3a. TIME OF DEATH: 7 45 PM
3b. DATE OF DEATH (Month, Day, Yr): JULY 24, 1990
4. SOCIAL SECURITY NUMBER: 314-05-3911
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): AUGUST 31, 1920
7. BIRTHPLACE (City and State or Foreign Country): Whiting, IN.
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): William Tumidalsky
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HIGHLAND.
13d. STREET AND NUMBER: 3418 - 42ND PLACE
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): Lawrence Vidovich
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Vasilik

INFORMANT

20a. INFORMANT'S NAME (Type/Print): William Tumidalsky
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3418 42nd Pl. Highland, Indiana
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Entombment [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 26, 1990 Catholic Cemeteries (St. John)
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Raymond White
22b. EMBALMER'S LICENSE NO.: FDO 8700086
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 308-7500

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.
Immediate Cause (Final disease or condition resulting in death): CONGESTIVE HEART FAILURE — Approximate Interval Between Onset and Death: 4 hrs
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF): DIABETES MELLITUS
DUE TO (OR AS A CONSEQUENCE OF): CARDIO-PULMONARY ARREST.
JUL 26 1990
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
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): 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): NO

CERTIFIER

29a. CERTIFIER (Check only one): [X] 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] MD
29c. MEDICAL LICENSE NO.: IN29300
29d. DATE SIGNED (Month, Day, Year): 7/24/90 JULY 24, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): N. S. SARDESAI, M.D. 921 FRAN LIN PARKWAY, MUNSTER, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] FILED
32. DATE FILED (Month, Day, Year): July 26, 1990

CORONER USE ONLY

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): APR
34d. DESCRIBE HOW INJURY OCCURRED: 18 1997
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.

SAM ORLICH
AUDITOR LAKE COUNTY
001098

Key # 27-332-25

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD APR 23 1990 MORRIS RECORDER