

\* ATTENTION ESTATE: The Social Security # is 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

CERTIFICATE OF DEATH

Local No. 2310-25

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) <b>Anthony Skifano</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>8:50 A</b>	3b DATE OF DEATH (Month Day Yr) <b>October 11, 1995</b>	
4 SOCIAL SECURITY NUMBER <b>317-09-7885</b>	5a AGE—Last Birthday (Years) <b>88</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) <b>Sep. 11, 1907</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Roselle, Louisiana</b>	8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)				
9a FACILITY NAME (If not institution, give street and number) <b>144 N. Dwiggins</b>		9c CITY, TOWN OR LOCATION OF DEATH <b>Griffith</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS <b>Married</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>Mary Penzato</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Burner</b>		12b KIND OF BUSINESS/INDUSTRY <b>Steel</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Griffith</b>	13d STREET AND NUMBER <b>144 N. Dwiggins</b>		
13e ZIP CODE <b>46319</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>	
17 DECEDENT'S EDUCATION (Specify any highest grade completed) Elementary/Secondary (8-12) <b>8</b> College (1-4 or 5+) <b>3</b>	18 FATHER'S NAME (First Middle Last) <b>Anthony Skifano</b>				
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Marie Schifano</b>				20a INFORMANT'S NAME (Type/Print) <b>Mary Skifano</b>	
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>144 N. Dwiggins Griffith, Indiana</b>		20c Relationship <b>Wife</b>			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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 (Name of cemetery, crematory or other place) <b>October 14, 1995 Calumet Park Cemetery</b>		21c LOCATION—City or Town, State <b>Merrillvill, Indiana</b>	
22a EMBALMER'S NAME <b>Ronald A. Reed</b>		22b EMBALMER'S LICENSE NO. <b>FDO 1001081</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) <b>FDO 1014511</b>	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9029 Klieberman Rd. Highland, Indiana FH83007560</b>		
<p><b>PART I</b> 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.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Wng Ca 2 Metastatic Disease</b> DUE TO (OR AS A CONSEQUENCE OF) <b>...</b></p> <p>Conditions if any which gave rise to the immediate cause causing the underlying cause last</p>					
<p><b>PART II</b> Other significant conditions - Conditions contributing to death but not previously stated in Part I</p> <p><b>OCT 13 1995</b></p>					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b AUTOPSY FINDINGS OR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
<p><b>CERTIFIER</b> (Check only one)  <input checked="" type="checkbox"/> <b>CERTIFYING PHYSICIAN</b> To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.  <input type="checkbox"/> <b>HEALTH OFFICER</b> 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.  <input type="checkbox"/> <b>CORONER</b> 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.</p>					
29a SIGNATURE AND TITLE OF CERTIFIER <b>Kendall R. Delta D.O.</b>		29b MEDICAL LICENSE NO. <b>02.00 1332</b>	29c DATE SIGNED (Month, Day, Year) <b>10/11/95</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>3100 45th St. Highland IN 46322</b>					
31 HEALTH OFFICER'S SIGNATURE <b>Wesley D. Williams, M.D.</b>				32 DATE SIGNED (Month, Day, Year) <b>October 13, 1995</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			

**FILED**

**SAM ORLICH  
AUDITOR LAKE COUNTY**

Key # 39-105-67+8

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