28-253-6

* 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.

Local No. 2103-97
201651

INDIANA STATE DEPARTMENT OF HEALTH

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)	Elizabeth Foldi
2 SEX	Female
3a TIME OF DEATH	9:31P M
3b DATE OF DEATH (Month Day Yr)	October 11,1997
4 SOCIAL SECURITY NUMBER	225-58-1398
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)	Jan.13,1929
7 BIRTHPLACE (City and State or Foreign Country)	Hungary
8a WAS DECEDENT A US 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 ☐ Other (Specify) ☐ Residence
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)	Married
11 SURVIVING SPOUSE (If wife give maiden name)	Antal Foldi
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	Home
13a RESIDENCE—STATE	IN
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Munster
13d STREET AND NUMBER	8245 Madison Ave
13e ZIP CODE	46321
13f INSIDE CITY LIMITS	☐ No X Yes
13g ON A FARM?	XNo ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XXNo ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12 / ---

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Janos Helle
19 MOTHER'S NAME (First Middle Maiden Surname)	Erzsebeth Antal

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Antal Foldi
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8245 Madison Ave. Munster,IN46321
20c Relationship	Husband

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	X Burial ☐ Cremation XX Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	October 17,1997 Madonna Cemetery
21c LOCATION—City or Town, State	Fort Lee, NJ
22a EMBALMER'S NAME	Brian T. Burns
22b EMBALMER'S LICENSE NO	8601763
23 WAS DEATH REPORTED TO CORONER?	XXNo ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Thomas J. Burns
24b LICENSE NUMBER (of Licensee)	1045184
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN 46321

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Metastatic Parotid Adenocarcinoma	8 yrs
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

FILED 1991

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

SAM ORLICH AUDITOR LAKE COUNTY

Field	Entry
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)	

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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	David M Harvey MD
29c MEDICAL LICENSE NO.	01017809
29d DATE SIGNED (Month Day Year)	October 13,1997
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	D. Harvey 716 Seberger Munster,IN 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER SIGNATURE	Alexander S. Williams, M.D.
32 DATE FILED (Month Day Year)	Oct 14,1997

Field	Entry
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.	

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

OCT 1997

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

9.00 pd

001921

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD OCT 1997

9707723

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