* 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.

LTIC 63430

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 8377-96 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)	MARY K. CORTESE
2. SEX	Female
3a. TIME OF DEATH	12:00 PM
3b. DATE OF DEATH (Month, Day, Yr)	May 27, 1996
4. *SOCIAL SECURITY NUMBER	303-62-7129
5a. AGE—Last Birthday (Years)	85
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Sept. 16, 1910
7. BIRTHPLACE (City and State or Foreign Country)	Chicago, IL
8a. WAS DECEDENT A U.S. VETERAN?	NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	NA
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Hobart
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)	Owner/Operator
12b. KIND OF BUSINESS/INDUSTRY	Self-Employed
13a. RESIDENCE—STATE	IN
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hobart
13d. STREET AND NUMBER	418 W. 37th Avenue
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	☒ No ☐ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ 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+)	9

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Joseph Servino
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Anna Rose Griffo

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Antonetta Delinck
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1235 W. 37th Place, Hobart, IN 46342
20c. Relationship	Daughter

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	May 30, 1996 Calvary Cemetery
21c. LOCATION—City or Town, State	Portage, IN
22a. EMBALMER'S NAME	James J. Krause
22b. EMBALMER'S LICENSE NO	FD01006463
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Rd., Hobart, IN 46342

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. congestive heart failure — one [illegible]
DUE TO (OR AS A CONSEQUENCE OF)
b. arteriosclerotic heart disease — [illegible] years
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

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

FILED
NOV 12 1997
SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
97 NOV 13
MORRIS W. CARTER RECORDER

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: 01020846

29d. DATE SIGNED (Month, Day, Year): 5/29/96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Donald Phillips, M.D., 1356 S. Lake Park Avenue, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]

32. DATE FILED (Month, Day, Year): 5/29/96

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

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

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)

OCT 23 1997

34g. DATE PRONOUNCED DEAD (Month, Day, Year)

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

000749

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

97 077854

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