

7cc re-sub

\* 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. 98-0030

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) <b>Juana Vives Torres</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>7:40 P M</b>	3b DATE OF DEATH (Month Day Year) <b>January 12, 1998</b>	
4 SOCIAL SECURITY NUMBER <b>312-42-6767</b>	5a AGE—Last Birthday (Years) <b>92</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>May 6, 1905</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Guayama, Puerto Rico</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"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a FACILITY NAME (If not institution give street and number) <b>1218 West 13th Avenue</b>		9b CITY TOWN OR LOCATION OF DEATH <b>Gary</b>		9c COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS <b>Married</b>	11 SURVIVING SPOUSE (If not, give maiden name) <b>Carlos M. Torres</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>		
12b KIND OF BUSINESS/INDUSTRY <b>Lake County Department of Welfare</b>		13a RESIDENCE—STATE <b>Indiana</b>			
13b COUNTY <b>Lake</b>		13c CITY TOWN OR LOCATION <b>Gary</b>		13d STREET AND NUMBER <b>1218 West 13th Avenue</b>	
13e ZIP CODE <b>46407</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? (If yes specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <b>Puerto Rican</b>	16 RACE—American Indian, Black, White, etc. (Specify) <b>No</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>0</b>					
18 FATHER'S NAME (First Middle Last) <b>Juan Leoncio Vives</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>Simona Sabater</b>			
20a INFORMANT'S NAME (Type/Print) <b>Carlos M. Torres</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1218 West 13th Avenue Gary, Indiana 46407</b>		20c Relationship <b>Husband</b>	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>January 15, 1998 Ridgelawn Cemetery</b>		21c LOCATION—City or Town, State <b>Gary, Indiana</b>	
22a EMBALMER'S NAME <b>Roosevelt Allen Sr.</b>		22b EMBALMER'S LICENSE NO. <b>#01051696</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) <b>#08700646</b>		24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Guy &amp; Allen Funeral Directors, Inc. #0007704 2959 West 11th Avenue Gary, Indiana 46404</b>	
25 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 organ failure. List only one cause on each line. <b>Colon carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Melastasis disease</b> DUE TO (OR AS A CONSEQUENCE OF)		<b>FILED</b> <b>APR 22 1998</b> <b>SAM ORLICH</b> <b>AUDITOR LAKE COUNTY</b>			
25 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
26 CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN 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"/> 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 <input type="checkbox"/> 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		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 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		29a SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			
29b MEDICAL LICENSE NO. <b>#01038216</b>		29c DATE SIGNED (Month Day Year) <b>2-7-98</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Alberto Sanchez, 2114 45th Avenue Highland, Indiana 46322</b>					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month Day Year) <b>2/19/98</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"/> Could not be determined <input type="checkbox"/> 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.			

DECEDENT

PARENTS

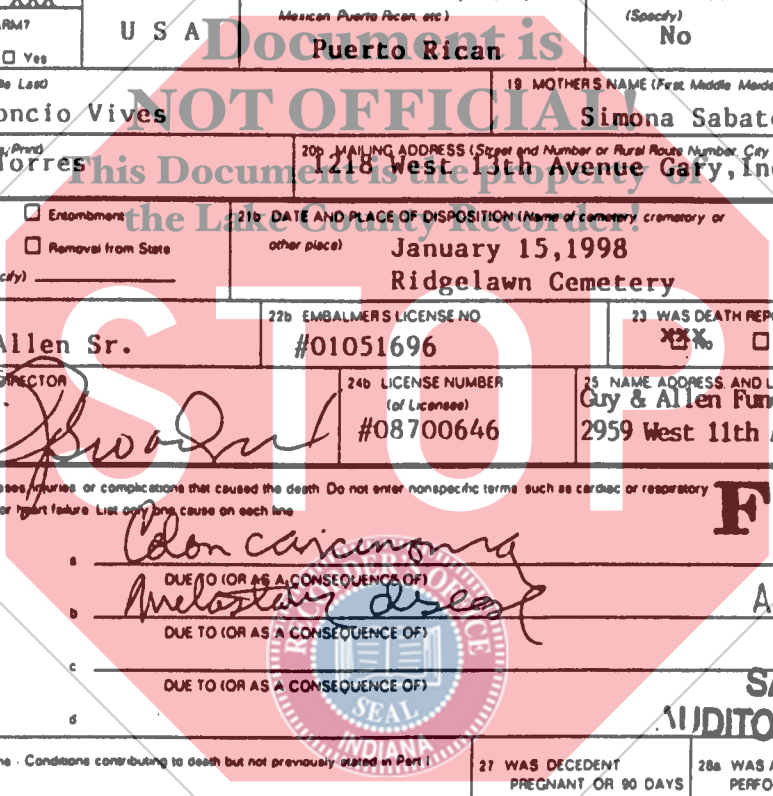
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

Teresa M. Brown  
1449 W. 18th Ave  
Gary, IN 46407



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**STOP**



*Robert M. Mph*  
CERTIFIED BY  
HEALTH COMMISSIONER  
FEB 19 1998