* 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. 322

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

HOLD FOR: THE TITLE SEARCH CO.

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): LILIA MARTINEZ

2 SEX: FEMALE

3a TIME OF DEATH: 11:17 PM

3b DATE OF DEATH (Month Day Yr): DECEMBER 29, 1997

4. *SOCIAL SECURITY NUMBER: 310 - 70 - 1065

5a AGE—Last Birthday (Years): 77

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo. Day. Yr): JUNE 9, 1920

7 BIRTHPLACE (City and State or Foreign Country): MARIN, MEXICO

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 ☐ Inpatient ☒ ER/Outpatient ☐ DOA

OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number): ST CATHERINE HOSPITAL

9c CITY, TOWN OR LOCATION OF DEATH: EAST CHICAGO

9d COUNTY OF DEATH: LAKE

10. MARITAL STATUS (Specify): Widowed

11 SURVIVING SPOUSE (If wife, give maiden name): n/a

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: OWN HOME

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN, OR LOCATION: EAST CHICAGO

13d STREET AND NUMBER: 4108 DEAL STREET

13e ZIP CODE: 46312

13f INSIDE CITY LIMITS ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): MEXICAN

16 RACE—American Indian, Black, White, etc (Specify): WHITE

17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): CANDIDO ELIZONDO

19. MOTHER'S NAME (First, Middle, Maiden Surname): ANTONIA LOPEZ

INFORMANT

20a INFORMANT'S NAME (Type/Print): BLANCA N. DELGADO

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4112 DEAL STREET, EAST CHICAGO, IN

20c Relationship: DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JANUARY 3, 1998 CALUMET PARK CEMETERY

21c LOCATION (City or Town, State): MERRILLVILLE, IN

22a EMBALMER'S NAME: Charles W. Wells

22b EMBALMER'S LICENSE NO: FD01024372

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: David L. Pastrick

24b LICENSE NUMBER (of Licensee): FD08800012

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: OLESKA-PASTRICK FUNERAL HOME 155 3934 ELM ST., EAST CHICAGO, IN

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):
a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive Heart failure

Conditions if any which gave rise to the immediate cause stating the underlying cause last

DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death:

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

27 WAS DECEDENT—PREGNANT OR WITHIN 90 DAYS OF POSTPARTUM? (Yes or no): NO

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 JAN 03 1998 SAM ORLICH AUDITOR LAKE COUNTY

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: Robert A. Flatem

29c MEDICAL LICENSE NO: 01029938 IN.

29d DATE SIGNED (Month, Day, Year): 12/30/1997

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. J. PATEL, M.D., 5500 HOHMAN AVENUE, HAMMIND, IN 46320

31 HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year): 12-30-97

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)

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.

900417

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

#15655