10 CC's

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 1049-91 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Jeanette Arabella Minniti
2. SEX: Female
3a. TIME OF DEATH: 12:35 AM
3b. DATE OF DEATH (Month Day Yr): May 10, 1991
4. SOCIAL SECURITY NUMBER: 308-36-2323
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day. Yr): July 21, 1921
7. BIRTHPLACE (City and State or Foreign Country): Warren, Ohio
8a. WAS DECEDENT A US VETERAN?: No
8b. YEAR LAST SERVED IN US ARMED FORCES?: --
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): Methodist Hospital Southlake Campus
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Robert J. Minniti, Sr.
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Clerical
12b. KIND OF BUSINESS/INDUSTRY: Public Utility Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 7713 Marshall Street
13e. ZIP CODE: 46410
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.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Albert W. Armour
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lola Mae White

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Robert J. Minniti, Sr.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7713 Marshall St., Merrillville, In. 46410
20c. Relationship: Husband

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): May 13, 1991 Calumet Park Cemetery
21c. LOCATION (City or Town, State): Merrillville, In.
22a. EMBALMER'S NAME: Ronald J. Mesarch
22b. EMBALMER'S LICENSE NO: FD01005912
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Ronald J. Mesarch
24b. LICENSE NUMBER (of Licensee): FD01005912
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410

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
DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Metabolic encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):

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

MAY 16 1991

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

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: Shannon McCarthy M.D.
29c. MEDICAL LICENSE NO:
29d. DATE SIGNED (Month, Day, Year): 5/15/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Shannon K. McCarthy, M.D. 8909 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year):

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
JUN 17 1998
SAM ORLICH
AUDITOR LAKE COUNTY

001373

900 Su es

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
98 JUN 17 PM 3:

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1