3cc'd

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 2215-88 State No. ....

99082050

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	CATHERINE KUCA
2. Sex	Female
3. Date of Death (Mo, Day, Yr)	October 25, 1988
4. Social Security Number	303-48-3640
5a. Age—Last Birthday (Years)	71
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Month, Day, Year)	5-8-1917
7. Birthplace (City and State or Foreign Country)	YUGOSLAVIA
8. Year Last Served in US Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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—Married, Never Married, Widowed, Divorced (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	VALENTINE KUCA
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	NONE
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town or Location	LAKE STATION
13d. Street and Number	3425 FLORIDA STREET
13e. Inside City Limits? (Yes or no)	YES
13f. Farm	NO
13g. Zip Code	46405
14. Was Decedent of Hispanic Origin? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
15. Race—American Indian, Black, White, etc. (Specify)	WHITE
16. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	8

PARENTS

Field	Entry
17. Father's Name (First, Middle, Last)	PHILLIP REMINCH (DECEASED)
18. Mother's Name (First, Middle, Maiden Surname)	THERESA SEBACH (DECEASED)

INFORMANT

Field	Entry
19a. Informant's Name (Type/Print)	VALENTINE KUCA
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3425 FLORIDA, LAKE STATION, IN 46405
19c. Relationship	SPOUSE

DISPOSITION

Field	Entry
20a. Method of Disposition	☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	October 28, 1988 CALVARY CREMATORY
20c. Location—City or Town, State	PORTAGE, INDIANA
21a. Signature of Funeral Director	Gerald V. Rees
21b. License Number (of Licensee)	FDE1041083
22. Name, Address, and License Number of Funeral Home	REES FUNERAL HOME-FDH3003069, 600 W. OLD RIDGE RD., HOBART, IN 46342

Box 488

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

Field	Entry
23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title	
23b. License Number	
23c. Date Signed (Month, Day, Year)	

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Field	Entry
24. Time of Death	3:16P M
25. Date Pronounced Dead (Month, Day, Year)	OCTOBER 25, 1988
26. Was Case Referred to Medical Examiner/Coroner? (Yes or no)	NO

CAUSE OF DEATH — SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardio-Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Septicemia
DUE TO (OR AS A CONSEQUENCE OF)
c. Severe Leucopenia-Chemo-Therapy
DUE TO (OR AS A CONSEQUENCE OF)
d. Oat Cell Carcinoma L Lung

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Hypertension

28a. Was an autopsy performed? NO
28b. Were autopsy findings available prior to completion of cause of death? (Yes or no)

CERTIFIER — SEE INSTRUCTIONS

29a. Certifier (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

Field	Entry
29b. Signature and Title of Certifier	[signature]
29c. License Number	01037179
29d. Date Signed (Month, Day, Year)	10/27/88
30. Name and Address of Person Who Completed Cause of Death (Item 27) (Type/Print)	SHASHIKANT R. RANE MD, 3820 CENTRAL AVENUE, LAKE STATION, IN 46405

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Cecil A Johnson MD
32. Date Filed (Month, Day, Year)	10-27-88

CORONER OR MEDICAL EXAMINER USE ONLY

Field	Entry
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)	

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9.00 e.p. CS

FILED OCT 05 1999

STATE OF INDIANA, LAKE COUNTY RECORDER — 99 OCT 5

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

Cecil A Johnson MD
LAKE COUNTY HEALTH COMMISSIONER

PETER BENJAMIN
LAKE COUNTY AUDITOR

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RECORDER'S OFFICE LAKE COUNTY INDIANA