* **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

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Jan 19 2000
Date Issued

Hammond Health Commissioner

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

Local No. ....59.....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

2000 001113

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Felix Santos Sr.	Male	2:15 AM	January 15, 2000

4 *SOCIAL SECURITY NUMBER	5a AGE (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
466-30-8503	72			February 11, 1927	Laredo, TX

8a WAS DECEDENT A U S VETERAN?	8b YEAR LAST SERVED IN U S ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
Yes	1945	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

RECORDER

9b FACILITY NAME (If not institution give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
527 Detroit Street	Hammond	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Maria M. Mendoza	Mobile Equipment Operator	Inland Steel Co.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	527 Detroit Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46324	☐ No ☒ Yes	☒ No ☐ Yes	USA	Mexican	White	6	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Maximanillo Santos	Elijah Hernandez

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Maria M. Santos	527 Detroit St., Hammond, IN 46324	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	January 18, 2000 Elmwood Cemetery	Hammond, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Henry J. Blake	FD01019406	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Edwin B. LaHayne	FD01000857	LaHayne Funeral Home, Inc., FH83002 5746 Hohman Ave., Hammond, IN 46320

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. Coronary artery disease
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

FILED
JAN 20 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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

diabetes mellitus

27 WAS DECEDENT PREGNANT OR WITHIN 1 YEAR POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
	01031576	01/18/2000 (January)

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Won S. Loh, MD, 9134 Columbia Ave., Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Grenada M.D.

32 DATE FILED (Month Day Year): January 19, 2000

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				9.00 E.P.

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)
	C5

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
	C1353

SDH06-004 State Form 10110 (R5/1-99)

25 x 10