

STATE OF INDIANA
LAKE COUNTY HEALTH
INDIANA STATE DEPARTMENT OF HEALTH
FILED FOR RECORD

Local No. **2000-013175** CERTIFICATE OF DEATH State No. _____

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-2

2000 FEB 28 AM 9:46

1 DECEASED - NAME (If not known last) **Rosalie Mislan MORRIS W. CARTER** 2 SEX **Female** 3a TIME OF DEATH **10:18p** 3b DATE OF DEATH (Month Day Year) **April 14, 1994**

4 SOCIAL SECURITY NUMBER **314-74-1454** 5a AGE - Last Birthday (Year) **77** 5b UNDER 1 YEAR (Month Day Year) **Feb. 16, 1917** 6 DATE OF BIRTH (Month Day Year) **FEB. 16, 1917** 7 BIRTHPLACE (City and State or Foreign Country) **Medaryville, Ind**

8a WAS DECEDENT A US VETERAN? **No** 8b YEAR LAST SERVED BY US ARMED FORCES? **N/A** 9a PLACE OF DEATH (Check only one. See instruction 1)
HOSPITAL **XIX Ingham** OTHER Nursing Home Other (Specify) _____
 ER/Outpatient DOA Residence

10 FACILITY NAME (If not institution give street and number) **St. Mary's Medical Center** 11a CITY/TOWN OR LOCATION OF DEATH **Hobart** 11b COUNTY OF DEATH **Lake**

12a MARRITAL STATUS **Married** 13 SURVIVING SPOUSE (If wife or husband name) **John Mislan** 14a DECEDENT'S USUAL OCCUPATION (Give kind of work) **Housewife** 14b KIND OF BUSINESS, INDUSTRY, ETC.

15a RESIDENCE - STATE **Indiana** 15b COUNTY **Lake** 15c CITY/TOWN OR LOCATION **Merrillville** 15d STREET AND NUMBER **6935 Fillmore St.**

16a ZIP CODE **46410** 16b INSIDE CITY LIMITS No Yes 16c CITIZEN OF WHAT COUNTRY? **USA** 16d WAS DECEDENT OF HISPANIC ORIGIN? No Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) 16e RACE - American Indian, Black, White, etc. (Specify) **White** 16f DECEDENT'S EDUCATION (Specify) **12**

17a FATHER'S NAME (Last Middle Last) **Faulkner** 17b MOTHER'S NAME (First Middle Maiden Surname) **Unk**

18a INFORMANT'S NAME (Type/print) **John Mislan** 18b MARITAL ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip) **6935 Fillmore St. Merrillville, IN** 18c Relationship **Husband**

19a METHOD OF DISPOSITION Entombment Burial Cremation Removal from State Donation Other (Specify) _____ 19b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) **April 18, 1994 Calumet Park Cemetery** 19c LOCATION - City or Town, State **Merrillville, IND.**

20a EMBALMER'S NAME **Anthony S. Rendina Jr.** 20b EMBALMER'S LICENSE NO **FD01010402** 20c WAS DEATH REPORTED TO CORONER? No Yes

21a SIGNATURE OF FUNERAL DIRECTOR *Anthony S. Rendina Jr.* 21b LICENSE NUMBER (of Licensee) **FD01010402** 21c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME **Rendina F. Home, FH#3007819 5100 Cleveland St. Gary, In**

22 PART I Enter the immediate cause of death on each line WITH THE LAKE COUNTY COMBINE HEALTH DEPT - **FILED FEB 25 2000**

IMMEDIATE CAUSE OF DEATH (Specify disease or condition resulting in death) _____
DUE TO (OR AS A CONSEQUENCE OF) _____
Conditions if any which gave rise to the immediate cause stating the underlying cause last _____

PART II Other significant conditions contributing to death but not directly stated in Part I _____

23 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) **no** 24 WAS AN AUTOPSY PERFORMED? (Yes or no) **no** 25 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) _____

26 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

27a SIGNATURE AND TITLE OF CERTIFIER *Milton Gasparis* 27b MEDICAL LICENSE NO **01037515** 27c DATE SIGNED (Month Day Year) **4-15-94**

28 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/print) **MILTON GASPARIS MD 1400 S. Lake Park Ave Hobart IN 46342**

29 HEALTH OFFICER'S SIGNATURE *Alexander S. Williams MD* 29a DATE SIGNED (Month Day Year) _____

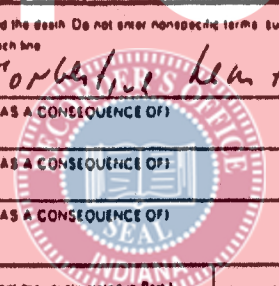
30 MANNER OF DEATH Natural Pending Investigation Accident Suicide Homicide Could not be Determined 31a DATE OF INJURY (Month Day Year) _____ 31b INJURY AT WORK? (Yes or no) **INJURY** 31c DESCRIBE HOW INJURY OCCURRED _____ 31d PLACE OF INJURY - At home (from street, factory, office, building, etc. (Specify) _____ 31e LOCATION (Street and Number or Rural Route Number, City or Town, State) _____

32a DATE PRONOUNCED DEAD (Month Day Year) _____ 32b MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. **815-5**

Chicago Tide Insurance Company

Key No. 15-23-248
Unit 2 Bldg 7 The Calveries of Merrillville

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900 Ct SW