STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2000 FEB 28 AM 9:46
MORRIS W. CARTER
RECORDER

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. CR 2000-013175 State No. .....

496206-DA THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-12

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Rosalie Mislan
2. SEX: Female
3a. TIME OF DEATH: 10:18p M
3b. DATE OF DEATH: April 14, 1994
4. SOCIAL SECURITY NUMBER: 314-74-1454
5a. AGE—Last Birthday: 77
5b. UNDER 1 YEAR (Days, Hours, Minutes): Months ____ Days ____ Hours ____ Minutes ____
6. DATE OF BIRTH (Mo. Day Yr.): FEb. 16, 1917
7. BIRTHPLACE (City and State or Foreign Country): Medaryville, Inc
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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Mary's Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John Mislan
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 6935 Fillmore St.
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS? [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): Faulkner
19. MOTHER'S NAME (First, Middle, Maiden Surname): unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John MIslan
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6935 Fillmore St. Merrillville, In
20c. RELATIONSHIP: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 18, 1994 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, INd.
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.: FD01010402
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S Rendina Jr
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Rendina F. HOme, FH03007819 5100 Cleveland St. Gary, In

CAUSE OF DEATH

26. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT abbreviate. Add additional lines if necessary.
IMMEDIATE CAUSE (Final disease or condition resulting in death): Cerebral hemorrhage
DUE TO (OR AS A CONSEQUENCE OF): ____
DUE TO (OR AS A CONSEQUENCE OF): ____
DUE TO (OR AS A CONSEQUENCE OF): ____
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last.
Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
27. WAS DECEDENT PREGNANT OR WITHIN 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)

CERTIFIER

29a. CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 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) and manner 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: Milton Gasparis
29c. MEDICAL LICENSE NO.: 01037515
29d. DATE SIGNED (Month, Day, Year): 4-15-94
30. 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

HEALTH OFFICER

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

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. HOUR 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.

$1555

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Chicago Title Insurance Company

Key No. 15-23-248 The Colonies of Meadowville Unit 2 Bldg 7

FILED
FEB 25 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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