6cc 132153

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# STATE OF INDIANA
# INDIANA STATE BOARD OF HEALTH
# CERTIFICATE OF DEATH

LAKE COUNTY FILED FOR RECORD

Local No. 1853-90 2000 019076 State No. .....

2000 MAR 21 AM 10:

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.) |
|---|---|---|---|---|
| ANNE M. | LATERZO | Female | 10:40A M | September 8,1990 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (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) |
|---|---|---|---|---|---|
| 315-28-8341 | 75 | | | March 14,1915 | Edenburg, Pennsylvania |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9. PLACE OF DEATH (Check only one. See instructions.) |
|---|---|---|
| -0- | -0- | HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| St Mary Med- Center | Hobart | 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 | Anthony Laterzo | Clerk | Calumet Township Truste |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Gary | 8200 Locust Avenue |

| 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+) |
|---|---|---|---|---|---|---|---|
| 46403 | [ ] No [X] Yes | [X] No [ ] Yes | U.S.A. | [X] No [ ] Yes | White | 12 | |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John Petrovich | Suzanna Suhanic |

**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 |
|---|---|---|
| Anthony Laterzo | 8200 Locust Ave. Gary, Indiana 46403 | Husband |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) | Sept. 12,1990 Calumet Park | Merrillville, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 22. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Henry Blake | FDE 1019406 | [X] No [ ] Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (or Limited) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Robert Wiatrolik | FDE 1001293 | Stilinovich & Wiatrolik Fh3004455 7535 Taft St. Merrillville In 46410 |

**CAUSE OF DEATH**

PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter terminal events such as cardiac or respiratory arrest, shock, or heart failure. Link only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | Ventricular Fibrillation | |
| DUE TO (OR AS A CONSEQUENCE OF) | Ischemic Heart Disease - Vessel | |
| 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.

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

1) Type I Diabetes mellitus 2) Diabetic Glomerulosclerosis 3) Uremia 4) Mitral Insufficiency

| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE SECTION? (Yes or no) |
|---|---|---|
| No | | |

PETER [illegible] LAKE COUNTY AUDITOR

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

**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) and manner 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 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 stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. MEDICAL LICENSE NO. | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John Scully MD | 17612 | 11 Sep 90 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
DR. John Scully 8895 Broadway Merrillville, Indiana

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE — Carl Johnson M.D. — Carl Johnson M.D. — SEP 11,'90

**CORONER USE ONLY**

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. [illegible] INJURY OCCURRED |
|---|---|---|---|---|
| [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide | | | | |

Anne N. Carlson AUDITOR LAKE COUNTY

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.

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HOLD FOR FIRST AMERICAN TITLE

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO # F31083