

Key no. 43-53-27-11

* 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

State No.

Local No. 0211-00

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

| | | | | | |
|---|---|---|--|--|----------------------------------|
| 1 DECEASED—NAME (First Middle Last) MILICA VUCENIC | | 2 SEX FEMALE | 3a TIME OF DEATH 10:55A | 3b DATE OF DEATH (Month Day Yr) JANUARY 21, 2000 | |
| 4 *SOCIAL SECURITY NUMBER 342-38-1291 | 5a AGE—Last Birthday (Years) 87 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Mo Day Yr) OCTOBER 3, 1913 | |
| 7 BIRTHPLACE (City and State or Foreign Country) YUGOSLAVIA | | 8a WAS DECEDENT A U.S. VETERAN? NO | | | |
| 8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE | | 9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | | |
| 9b FACILITY NAME (If not institution give street and number) METHODIST HOSPITAL SOUTHLAKE | | 9c CITY TOWN OR LOCATION OF DEATH MERRILLVILLE | 9d COUNTY OF DEATH LAKE | | |
| 10 MARITAL STATUS (Specify) MARRIED | 11 SURVIVING SPOUSE (If wife give maiden name) LAZAR VUCENIC | 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 DOMESTIC | |
| 13a RESIDENCE—STATE INDIANA | 13b COUNTY LAKE | 13c CITY TOWN OR LOCATION MERRILLVILLE | 13d STREET AND NUMBER 3360 E. 78th. Pl. | | |
| 13e ZIP CODE 46410 | 13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14 CITIZEN OF WHAT COUNTRY? YUGOSLAVIA | 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | 16 RACE—American Indian Black White etc (Specify) WHITE | |
| 17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) N/A College (11-4 or 5+) N/A | | 18 FATHER'S NAME (First Middle Last) ILIJA BACKU | | | |
| 19 MOTHER'S NAME (First Middle Maiden Surname) IKA BERIC | | 20a INFORMANT'S NAME (Type/Print) LAZAR VUCENIC | | | |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 3360 E. 78th. Pl. | | 20c Relationship HUSBAND | | | |
| 21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Remove from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) JANUARY 25, 2000 ST. SAVA CEMETERY | | 21c LOCATION—City or Town State LIBERTYVILLE, ILLINOIS | |
| 22a EMBALMERS NAME CHARLES WELLS | | 22b EMBALMERS LICENSE NO. FD1042372 | 23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | |
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>Eli [Signature]</i> | | 24b LICENSE NUMBER FD1008300 | 25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307 | | |
| 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a <i>MI</i> b <i>Insular treatment diabetes mellitus</i> c <i>MI</i> DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) Approximate Interval Between Onset and Death | | | | | |
| PART II: Other significant conditions. Conditions contributing to death but not previously stated in Part I. | | | | | |
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) | | 28a WAS AN AUTOPSY PERFORMED? (Yes or no) JUN 0 2000 | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) | | |
| 29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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. PETER BENJAMIN LAKE COUNTY AUDITOR | | | | | |
| 29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c MEDICAL LICENSE NO. 01026620 | 29d DATE SIGNED (Month Day Year) 1-25-00 | | |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Nadezda Purcic 2105 W. Lincoln Hwy Merrillville, IN 46410 | | | | | |
| 31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> | | | 32 DATE FILED (Month Day Year) January 25, 2000 | | |
| 33 MANNER OF DEATH <input checked="" type="checkbox"/> Nature <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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) | | |
| 34g DATE PRONOUNCED DEAD (Month Day Year) | | 34h MOTOR VEHICLE ACCIDENT? (Yes or no; If yes specify driver, pedestrian, etc.) | | | |

DECEDENT

PARENTS

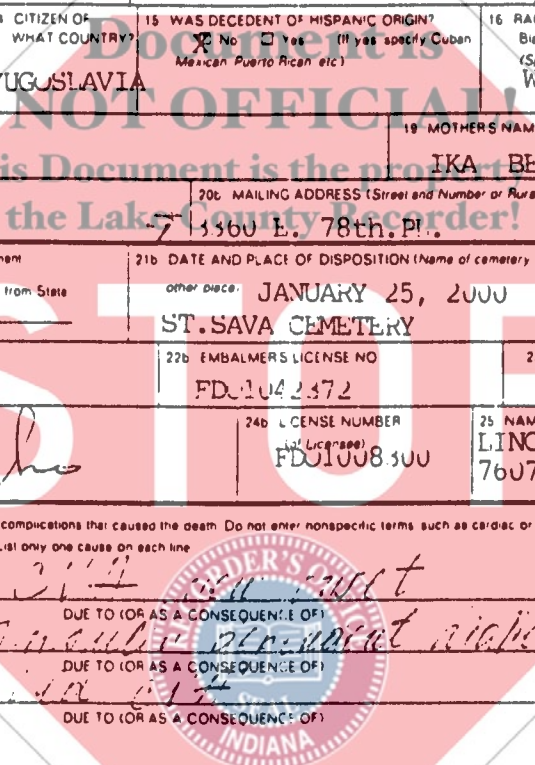
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



FILED