ATTENTION ESTATE: The Social Security # is ing requested by this state agency in order to rsue its statutory responsibility. Disclosure is luntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH 53-44-1

CERTIFICATE OF DEATH

Local No. 1679-00 State No.

93025

TYPE/PRINT IN PERMANENT BLACK INK

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

STATE FILED

DECEDENT

1 DECEASED—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
MILDRED	MACCHIA	Female	10:49pm	July 17, 2000

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)
308-32-2686	2000	05	56	June 11, 1934	STerling, Ill.

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)
No	N/A	HOSPITAL XX 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
Methodist Southlake Campus	Merrillville	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	Rev. MIke Macchia	Housewife	

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hobart	7434 GRand Blvd

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)	
46342	☐ No XX Yes	XX No ☐ Yes	USA	XX No ☐ Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Raymond MOran	Sarah Knapp

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
REv. Mike Macchia	7434 Grand Blvd, Hobart, In 46342	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
XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	July 21, 2000 Calumet Park Cemetery	Merrillville, Ind.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Anthony S. Rendina Jr.	FD01010402	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Anthony S. Rendina (THIS CERTIFIES THE ABOVE IS A TRUE AND ... DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.)	FD01010402	Rendina Funeral HOme FH83007819 5100 Cleveland St. GAry, In46408

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)	AUG 02 2000 Vertebral Basilar Artery Thrombosis	one day
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF)	
	DUE TO (OR AS A CONSEQUENCE OF)	
	DUE TO (OR AS A CONSEQUENCE OF)	

Alexander D. Killinec MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
AUG 3 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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

Ischemic Heart Disease
Cardiomegaly - Class IV
Chronic Obstructive Lung Disease

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 (Yes or no)
No	No	No

CERTIFIER

29a CERTIFIER (Check only one)

XX 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)
John T. Scully, M.D.	0101 7621	18 July 00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

8895 Broadway Merrillville, In 46410 - JOHN T. SCULLY, M.D.

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Alexander D. Killinec MD	July 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				

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
	00351

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

CASH 9.00 AM

25 x 10