2000-059445

* 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.

Local No. 2290-99

264270

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Laura Nisevich
2. SEX: Female
3a. TIME OF DEATH: 4:40A M
3b. DATE OF DEATH (Month, Day, Yr): October 5, 1999
4. SOCIAL SECURITY NUMBER: 309-76-9593
5a. AGE—Last Birthday (Years): 84
5b. UNDER 1 YEAR (Months / Days)
5c. UNDER 1 DAY (Hours / Minutes)
6. DATE OF BIRTH (Mo. Day, Yr): Dec.20,1914
7. BIRTHPLACE (City and State or Foreign Country): Calumet City, IL
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Regency Nursing Place
9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Stephen Nisevich
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: Home
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 1462 Summer St.
13e. ZIP CODE: 46320
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): ---

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Bissa
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Zentz

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Cheryl Johnson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1017 Heather Ln. Munster, IN 46321
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 8, 1999 Regional Cremation SV
21c. LOCATION—City or Town, State: Munster, IN
22a. EMBALMER'S NAME: John T. Noble
22b. EMBALMER'S LICENSE NO.: 900031
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b. LICENSE NUMBER (of Licensee): 1045184
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter mode of dying, 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)
a. FTT w/ ischemic ulcers

DUE TO (OR AS A CONSEQUENCE OF)
b. HTN

DUE TO (OR AS A CONSEQUENCE OF)
c. CVA

DUE TO (OR AS A CONSEQUENCE OF)
d. DM

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 previously stated in Part I

27. WAS DECEDENT PREGNANT OR 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):
☒ 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: x [signature]
29c. MEDICAL LICENSE NO.: 01025591
29d. DATE SIGNED (Month, Day, Year): Oct. 8, 1999
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A. Stemer, M.D. 761 45th Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): October 12, 1999

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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, passenger, pedestrian, etc.

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

OCT 12 1999

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
AUG 16 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1