2000-0598 (Gana State Board of Health CERTIFICATE' OF DEATH 34 TIME OF DEATH 36 DATE OF DEATH (Month Day Y E/PRINT **ANNA** 5:20AM u May 14, 1991 PEREVUZNIK **Female** Se AGE-Last Birthdey (Years) 56 UNDER LYEAR **MANENT** SOCIAL SECURITY NUMBER SC UNDER I DAY & DATE OF BIRTH (Mg Oev Yr) Days East Obicago, Indiana ide Insurance Campanys 306-01-5105 D 89 MAS DECEDENT A US VETERAN? YEAR LAST SERVED IN US ARMED FORCES? ☐ Inpetient Nursing Home Other (Specify) HOSPITAL No ☐ ER/Outpetient Residence 9c. CITY, TOWN, OR LOCATION OF DEATH 9d. COUNTY OF DEATH 96 FACILITY NAME (If not institution, give street and number) Dyer Lake Meridian Nursing Center 11. SURVIVING SPOUSE (If wife, give meiden nem 12a DECEDENT'S USUAL OCCUPATION (Give kind of work 126 KIND OF BUSINESS/INDUSTRY Widow Housewife 134 RESIDENCE-STATE 13c. CITY, TOWN, OR LOCATION 3d STREET AND NUMBER 13b COUNTY 9 7215 Woodlawn Hammond Indiana WAS SECEDENT OF HISPANIC ORIGIN?

LYNO D Yes (If yes, specify Communication, Priesto Rican, etc.) 13e ZIP CODE 13F INSIDE CITY LIMITS 14 CITIZEN OF 17 DECEDENT'S FOUCATION College (1-4 pr 5 +) 13g ON A FARM? 46324 6 years XX No 0 Yes 18 FATHER'S NAME (First Mickelle Land) Johanna Oris Vasil Suranich 20s INFORMANT S NAME (Type/Print) Mary Anderson 7215 Woodlawn Hammond, Indiana 46324 Daughter 218 METHOD OF DISPOSITION | Entomb 21b DATE AND PLACE OF DISPOSITION (Name of cometery, cremetory, or ☐ Cremetion ☐ Removel from Sta other place) May 17, 1991 Other (Specify) ☐ Donetion Holy Ghost Cemetery Hammond, Indiana 23 WAS DEATH REPORTED TO CORONER? 22ª EMBALMER'S NAME 226 EMBALMER'S LICENSE NO POSITION XIXIX □ Vac Charles W. Wells #1042372 246 SIGNATURE OF FUNERAL DIRECTOR 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL, HOME 246 LICENSE NUMBER SOLAN FUNERAL HOME FH# 3002893 (of Licensee) 7109 Calumet Ave., Hammond, Ind. FD# 1004097 IMMEDIATE CAUSE (Fine DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) 286. WERE AUTOPSY FINDINGS 284 WAS AN AUTOPSY Anderson Entich TH POSTPARTUME COMPLETION OF CAUSE (Yes or no) NO OF DEATH? (Yes or no) 29a CERTIFIER X KERTIFYING PHYSICIAN To the best of my kn HEALTH OFFICER On the basis of exen 14-10 Fin D. 10 110 CO CORONER On the besis of exam 296 SIGNATURE AND TITLE OF CERTIFIER 29d DATE SIGNED (Month, Day, Year) 290 MEDICAL LICENSE NO RTIFIER AUG 17 2000 May 14, 1991 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) 800 MacArthur Fred M. Adler MD Munster, Indiana 11 HEALTH OFFICER'S SIGNATURE FER BENJAMIN ALTH **FICER** 34a DATE OF INJURY 34c INJURY AT WORKS 33 MANNER OF DEATH (Month, Day, Year) IN.AJRY (Yes or no) 01184 ☐ Natural ☐ Accident 34e PLACE OF INJURY-At home, farm street, factory, office 34f LOCATION (Street and Number or Rural Route Number, City or Town, State) RONER ☐ Suicide **E ONLY** DATE PRONOUNCED DEAD (Month, Day, Year) 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, pessenger, p

DEA CERT/PD 1

SBH06-004

State Form 10110 (R2/3-89)

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