* 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. 1339

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

APR. 14, 1999 — Date Issued

[signature] — Hammond Health Commissioner

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2000 SEP -6 AM 10: 15

MORRIS W. CARTER RECORDER

2000 061623

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	Joseph De La Riva
2 SEX	Male
3a TIME OF DEATH	3:25 P.M.
3b DATE OF DEATH (Month, Day, Yr)	April 11, 1999
4 *SOCIAL SECURITY NUMBER	352-34-0716
5a AGE—Last Birthday (years)	55
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo, Day, Yr)	October 9, 1943
7 BIRTHPLACE (City and State or Foreign Country)	Mexico
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	1967
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	St. Margaret Mercy Hospital
9c CITY, TOWN OR LOCATION OF DEATH	Hammond
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Suzanne Bielat
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Systems Analyst
12b KIND OF BUSINESS/INDUSTRY	Oil Company
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	521 - 138TH Street
13e ZIP CODE	46327
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☐ No ☒ Yes — Mexican
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	John De La Riva
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Angela Barrera

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Suzanne De La Riva
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	521-138TH Street, Hammond, Indiana 46327
20c Relationship	Wife

DISPOSITION

Field	Entry
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)	April 15, 1999 St. Michael Cemetery
21c LOCATION—City or Town, State	Hammond, Indiana
22a EMBALMER'S NAME	Keith D. Anthony
22b EMBALMER'S LICENSE NO	01011911
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature] Keith D. Anthony
24b LICENSE NUMBER (of Licensee)	01011911
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Anthony & Dziadowicz FH 83002835, 4404 Cameron, Hammond, Indiana 46327

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)

a. Liver Failure

DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

FILED

SEP 6 2000

PETER BENJAMIN LAKE COUNTY AUDITOR

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STOP

RECORDER'S OFFICE SEAL INDIANA

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
[signature] MD	1035923	4/14/99

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

J. Cahan, M.D. 7905 Calumet Ave. Munster, Indiana 46321 — April 14, 1999

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
[signature] M.D.	April 14, 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.

9.00

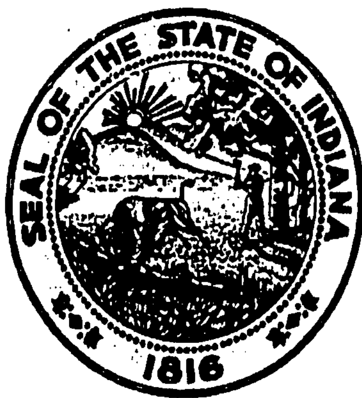
SP

CS

291

Douglas Park Manor Resub Lot 13 to 25 Block 7 Lot "1" unit #26 Key #33-212-9

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



Official Stamp

2000 064623

STATE OF INDIANA
LAKE COUNTY
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MORRIS W. CARTER
RECORDER

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RECORDER'S OFFICE SEAL INDIANA

This is where you want the recorded document sent back to when it has completed the recording process.

Name: Mrs. Suzanne DeLaRiva

Address: 521- 138th Street

City St Zip: HAMMOND, In 46327

Telephone: (219) 937-3669

Signature Printed: ______

Signature Written: ______

Date of Signature: ______

Check Number: ______

Check Amount: ______

Cash 9.00

Office Use Only

Check Equals Amount Due ☐Yes ☐No

Total ______

Initials ______