INDIANA STATE BOARD OF HEALTH

Local No. 247 — **CERTIFICATE OF DEATH** — State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
ISIDRO EDUARDO ARROYO	MALE	7:06 a M	August 11, 1992

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)
312-34-8638	71			May 4, 1921	Caguas, Puerto Rico

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: ☒ 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
St Catherine Hospital	East Chicago	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	Leonida Hernandez	Steelworker	Inland Steel

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	East Chicago	3818 Deodar Street

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)	
46312	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☐ No ☒ Yes Puerto Rican	White	Elementary, Secondary (0-12): N/A	College (1-4 or 5 +)

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Eduardo Arroyo	Felipa Rivera

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
Leonida Hernandez	3818 Deodar St.East Chicago, IN46312	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	August 15, 1992 Ridgelawn Cemetery	Gary, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Charles W. Wells	FD0104372	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
David Patrick	FD08800012	Oleska-Pastrick Funeral Home#155 3934 Elm St.East Chicago, IN46312

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 Intestinal Telangiectasia

DUE TO (OR AS A CONSEQUENCE OF)

b Exsplitatory Failure

DUE TO (OR AS A CONSEQUENCE OF)

c

DUE TO (OR AS A CONSEQUENCE OF)

d

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

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 19 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

STATE OF INDIANA RECORDED AND CERTIFIED SEP 18 2000 MORRIS W. CARTER RECORDER

20000681157

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)
Rose Ann Madarang M.D.	31927	8/14/92

HEALTH OFFICER

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

Rose Ann Madarang, M.D. , 9337 Calumet Ave. #A-1, Munster, IN 46321

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
M. Jeanette Kaykendall	8-14-92.

CORONER USE ONLY

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)
	911.1

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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