

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 39-15-31
39-379-18

Local No. 0417-94

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Egidio Ruzzini		2 SEX Male	3a TIME OF DEATH 2:14p.m.	3b DATE OF DEATH (Month, Day, Yr) February 27, 1996
4. *SOCIAL SECURITY NUMBER 306-03-5277		5a AGE—Last Birthday (Year, Month, Day) 80	5b UNDER 1 DAY 0 15 07	5c UNDER 1 DAY Hours Minutes 0 15 07
6. MONTH OF BIRTH Sept. 18, 1915		7. PLACE OF BIRTH (City and State or Foreign Country) Ableman, Wisconsin		
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a. PLACE OF DEATH (Check only 1 box. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> RECORDER <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) St. Mary's Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Matilda Romischer	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Retired Steelworker		12b. KIND OF BUSINESS/INDUSTRY Inland Steel Co.
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 1680 W. 39th Ct.	
13e. ZIP CODE 46408	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 12		18. FATHER'S NAME (First, Middle, Last) Canuto Ruzzini		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Angela Trentin		20a. INFORMANT'S NAME (Type/Print) Matilda Ruzzini		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1680 W. 39th Ct. Gary, In 46408		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 2, 1996 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, Ind.
22a. EMBALMER'S NAME Anthony S. Rendina Jr.		22b. EMBALMER'S LICENSE NO. FD01010402		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr.</i>		24b. LICENSE NUMBER (of licensee) FD01010402		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home FH83007819 5100 Cleveland St. Gary, In 46408
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 coma. Do not use "and" or "with" to connect terms. Enter the date and time of death. This certifies the above is a true and complete copy of the certificate of death on file with the Lake County Health Dept.				Approximate Interval Between Onset and Death = Days
IMMEDIATE CAUSE (The disease or condition resulting in death) HEALTH DEPT				DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last FEB 29 1996				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>intercoronary heart disease</i> LAKE COUNTY HEALTH COMMISSIONER				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Donald M. Phillips M.D.</i>		29c. MEDICAL LICENSE NO. 01020846		29d. DATE SIGNED (Month, Day, Year) 02/28/96
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DONALD M. PHILLIPS M.D. 1356 S. LAKE PARK AVE HEB IN 46342				32. DATE FILED (Month, Day, Year) February 29, 1996
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams M.D.</i>				FILED
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED 13202		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) PETER BENJAMIN LAKE COUNTY AUDITOR		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		600790		