

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

32-97-15

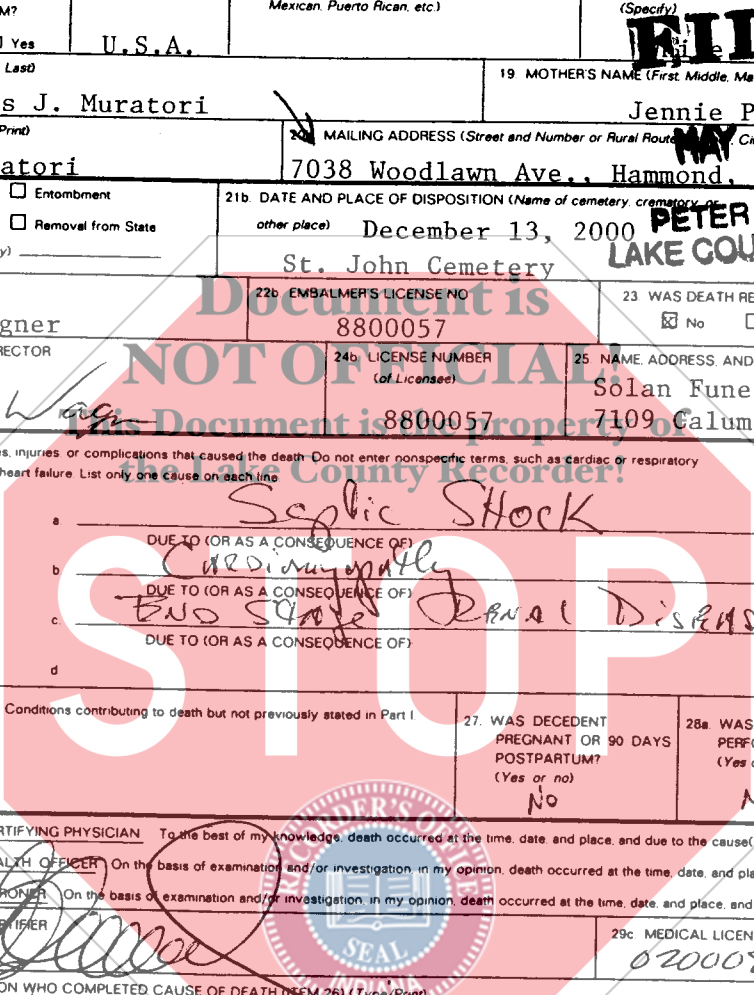
Local No. 2848-00

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) JAMES J. MURATORI, SR.		2 SEX Male	3a TIME OF DEATH 10:30 PM	3b DATE OF DEATH (Month Day, Yr) December 7, 2000	
4 *SOCIAL SECURITY NUMBER 303-34-7094		5a AGE—Last Birthday (Mo) (Day) (Yr) 2002 68 04 21 13	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) March 9, 1932		7 BIRTHPLACE (City and State or Foreign Country) Terre Haute, Indiana			
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) Community Hospital		9c CITY, TOWN, OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Romana Mauch	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Warehouse Worker		12b. KIND OF BUSINESS/INDUSTRY Rhone Poulenc Rorer	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond	13d. STREET AND NUMBER 7038 Woodlawn Avenue	
13e. ZIP CODE 46324	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) High School Graduate (10-12) College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) James J. Muratori			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Pellegrini		20a. INFORMANT'S NAME (Type/Print) Romana Muratori			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7038 Woodlawn Ave., Hammond, IN. 46324		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) December 13, 2000 St. John Cemetery Hammond, Indiana			
22a. EMBALMER'S NAME Dean G. Wagner		22b. EMBALMER'S LICENSE NO. 8800057		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b. LICENSE NUMBER (of Licensee) 8800057		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN. 46324	
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sepsis Shock				Approximate Interval Between Onset and Death	
DUE TO (OR AS A CONSEQUENCE OF) Cardiovascular Disease					
DUE TO (OR AS A CONSEQUENCE OF) End Stage Renal Disease					
DUE TO (OR AS A CONSEQUENCE OF)					
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) 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) NA	
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>James J. Muratori</i>			29c. MEDICAL LICENSE NO. 02000848	29d. DATE SIGNED (Month Day, Year) 12-12-00	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 222 Douglas St Hammond IN 46320					
31. HEALTH OFFICER'S SIGNATURE <i>James J. Muratori, M.D.</i>			32. DATE FILED (Month, Day, Year) December 13, 2000		
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 DEC 13 2000 000187 BD 900 cash
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



FILED
MAY 6 2002

PETER BENO
LAKE COUNTY AVIATION