

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

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

Local No. 981

DATE ISSUED: 12/15/99
Date Issued: Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Eulogio B. Nieves		2 SEX Male	3a TIME OF DEATH 10:25aM	3b DATE OF DEATH (Month, Day, Year) December 14, 1999	
4 *SOCIAL SECURITY NUMBER 296-30-8596		5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months: Days	5c UNDER 1 DAY Hours: Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) April 11, 1930		7 BIRTHPLACE (City and State or Foreign Country) Aguadilla, Puerto Rico			
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? -	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 7405 California Avenue		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) Alejandrina Medina	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Scarfer		12b KIND OF BUSINESS/INDUSTRY Inland Steel Co.	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond		
13d STREET AND NUMBER 7405 California Avenue		13e ZIP CODE 46323			
13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Puerto Rican		16 RACE—American Indian, Black, White, etc. (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6 College (1-4 or 5+): -	
18 FATHER'S NAME (First, Middle, Last) Tomas Roldan		19 MOTHER'S NAME (First, Middle, Maiden Surname) Fabiana Nieves			
20a INFORMANT'S NAME (Type/Print) Alejandrina Nieves		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7405 California Ave., Hammond, IND 46323		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 17, 1999 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Indiana	
22a EMBALMER'S NAME James H. Fife		22b EMBALMER'S LICENSE NO. FD01010795	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>John D. Fife</i>		24b LICENSE NUMBER (of Licensee) FD01020366	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME, INC. - FH83001512 4201 Indpls. Blvd., East Chicago, IND		
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) a. Acute Coronary Event DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus II DUE TO (OR AS A CONSEQUENCE OF): Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last PETER BENJAMIN LAKELAND COUNTY AUDITOR					
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) - NC	
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>J. Perez</i>		29c MEDICAL LICENSE NO. 101027498	29d DATE SIGNED (Month, Day, Year) Dec. 14, 1999		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. J.F. Perez, M.D. - 513 Ridge Road, Munster, Indiana 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Serna, M.D.</i>				32 DATE FILED (Month, Day, Year) December 15, 1999	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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
34a 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) BD 700 000976 Ash			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

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MAY 10 2002

