

INDIANA STATE BOARD 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. 43

Date Issued: Jan 16, 1992
Hammond Health Commissioner: *Franklin S. Remuda, M.D.*

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

Key # 35-374-2, UN-#26
Geo. Ruston's Add lot 9 Block 3

Beckman, Kelly & Smith, 5920 Holman Ave., Hammond, In, 46320

1. DECEASED—NAME (First, Middle, Last) MARTIN V. GONZALES				2. SEX MALE		3a. TIME OF DEATH 2:55 PM		3b. DATE OF DEATH (Month, Day, Yr.) JANUARY 15, 1992	
4. SOCIAL SECURITY NUMBER 316-03-6825		5a. AGE—Last Birthday (Years) 72		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:		6. DATE OF BIRTH (Mo, Day, Yr.) Nov. 20, 1919	
7. BIRTHPLACE (City and State or Foreign Country) Brownsville, Texas		8a. WAS DECEDENT A U.S. VETERAN? yes WWII		8b. YEAR LAST SERVED IN U.S. ARMED FORCES 1945		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) Residence: 5717 Northcote				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) Elizabeth Kavanaugh		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Millwright		12b. KIND OF BUSINESS/INDUSTRY Inland Steel			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hammond		13d. STREET AND NUMBER 5717 Northcote			
13e. ZIP CODE 46320		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.) Mexican	
16. RACE—American Indian, Black, White, etc. (Specify) white		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 10 College (1-4 or 5+):				18. FATHER'S NAME (First, Middle, Last) Ignaciou Gonzales			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Isidra Vega				20a. INFORMANT'S NAME (Type/Print) Mrs. Elizabeth Gonzales		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5717 Northcote Hammond, IN 46320		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) January 18, 1992 St. Joseph Cemetery				21c. LOCATION—City or Town, State Hammond, Indiana			
22a. EMBALMER'S NAME David McCoy		22b. EMBALMER'S LICENSE NO. FD08700581		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes				24. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	
24b. LICENSE NUMBER (of Licensee) FD01013507		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Avenue Hammond, IN 46323				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. cardio respiratory arrest cadave arrest			
26. 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) 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>[Signature]</i>		29c. MEDICAL LICENSE NO. 01030973		29d. DATE SIGNED (Month, Day, Year) Jan. 16, 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Tae H. Park, M.D. 8731 Indianapolis Blvd. Highland, IN 46322		31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) January 16, 1992				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			
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.		34i. 9.00				34j. 001744			

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the Lake County Recorder

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DEC 2 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

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