INDIANA STATE DEPARTMENT OF HEALTH

Local No. 278 — **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)
Cruz T. Torres	Male	3:05a M	September 18, 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)
313-30-6095	75			Oct. 1, 1916	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	---------	HOSPITAL: [X] 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's 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	Herminia Munoz	Retired Steelworker	INland Steel Co

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INdiana	Lake	East Ch icago	1909 - 138th

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 [X] Yes	[X] No [ ] Yes	USA	Puerto Rican	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Santos Torres	Amelia Irizarry

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
Herminia Torres	1909 - 138th East Chicago, In	Spouse

DISPOSITION

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

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Anthony S. Rendina Jr.	FD 01010402	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Anthony S Rendina Jr	FD01010402	Rendina F. Home FH 83007819 5100 Cleveland St Gary, In 464

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Acute Pulmonary Edema
DUE TO (OR AS A CONSEQUENCE OF)
b. Hypertensive Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Diabetes Mellitus type II
DUE TO (OR AS A CONSEQUENCE OF)
d. Coronary Artery Disease

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

Approximate Interval Between Onset and Death: MONTHS / DAYS / HOURS / MINUTES

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Resect AVA

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28. WAS AN AUTOPSY PERFORMED? (Yes or no)	29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	---------

CERTIFIER

29a. CERTIFIER (Check only one)
[X] CERTIFYING PHYSICIAN. To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) 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) and manner 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)
[signature] M.D.	27460	9/21/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ROSITA L. JAVATE MD. 720 W. CHICAGO, EAST CHICAGO IN 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	9-21-92

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
			600597

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.

Natural Issues

SDH06-004 State Form 10110 (R/1-92) DEATHCER/PD 1

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FILED FOR RECORD — STATE OF INDIANA — LAKE COUNTY — 2004 APR 1 — STEPHEN R. STIGLICH — LAKE COUNTY AUDITOR

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