* **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

Local No. 116 State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JESUS SAUCEDO
2. SEX: MALE
3a. TIME OF DEATH: 10:40P M
3b. DATE OF DEATH (Month, Day, Yr.): APRIL 18, 2004
4. *SOCIAL SECURITY NUMBER: 466-22-0297
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo. Day. Yr): SEPT. 18, 1925
7. BIRTHPLACE (City and State or Foreign Country): LAREDO, TEXAS
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. CATHERINE HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: EAST CHICAGO
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MARIA FLORES
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CRANE OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: INLAND STEEL CO.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: WHITING
13d. STREET AND NUMBER: 1504 JOHN STREET
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☐ No XX 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): 4; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): MANUEL SAUCEDO
19. MOTHER'S NAME (First, Middle, Maiden Surname): LUISA ZAPATA

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MRS. MARIA SAUCEDO
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1504 JOHN, WHITING, IN 46394
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial XX Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 21, 2004 HERITAGE CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: HENRY J. BLAKE
22b. EMBALMER'S LICENSE NO.: FDE01019406
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Martha A. Flick
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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. Cardiac dysrhythm. VT
DUE TO (OR AS A CONSEQUENCE OF):
b. hypoxic encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. etio. cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death

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): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

CERTIFIER

29a. CERTIFIER (Check only one): XX CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as 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) 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: 01032690
29d. DATE SIGNED (Month, Day, Year): APR. 20, 2004

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SAMI AHMADZAI, M.D., 6924 INDIANAPOLIS BLVD., HAMMOND, INDIANA 46324
31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Raymond
32. DATE FILED (Month, Day, Year): 4/21/04

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

SDH06-004 State Form 10110 (R5/1-99)

Unit #28 Key #29-3-40 PT SE NE S.7 T.37 R.9

5436 Molesberger Place Hammond, IN 46320