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* **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. 2444-01

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): SUZANNE M. LARRANCE
2. SEX: FEMALE
3a. TIME OF DEATH: 4:15 AM
3b. DATE OF DEATH (Month, Day, Yr): OCTOBER 28, 2001
4. *SOCIAL SECURITY NUMBER: 313-64-1420
5a. AGE—Last Birthday (Years): 46
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): JULY 16, 1955
7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 304 E. NORTH STREET
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): RICHARD H. LARRANCE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): REGISTERED NURSE
12b. KIND OF BUSINESS/INDUSTRY: ST. ANTHONY HOSPITAL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 304 E. NORTH STREET
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☐ No X Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? X No ☐ 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): Elementary/Secondary (0-12): ; College (1-4 or 5+): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last): HENRY P. MARSZALEK
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY C. MARIO

INFORMANT

20a. INFORMANT'S NAME (Type/Print): RICHARD L. LARRANCE
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 E. NORTH ST., CROWN POINT, IN 46307
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial XX Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): OCTOBER 31, 2001 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: THOMAS G. PRUZIN
22b. EMBALMER'S LICENSE NO.: 1009893
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN & LITTLE FUNERAL SERVICE #830012 811 E. FRANCISCAN DR., CROWN POINT, IN 46307

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. Ovarian Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
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)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): --

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: [signature] Drasga
29c. MEDICAL LICENSE NO.: 31484
29d. DATE SIGNED (Month, Day, Year): OCTOBER 31, 2001
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. DRASGA CANCER HEALTH ASSOC 8127 Merrillville Road, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W. Burt D.O.
32. DATE FILED (Month, Day, Year): October 31, 2001

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
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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

NOV 01 2001

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FILED
MAY 21 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1