

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. 76

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

3 DECEDENT

PARENTS INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) **Margarita Navarro** 2 SEX **female** 3a TIME OF DEATH **1:55A M** 3b DATE OF DEATH (Month, Day, Yr) **March 15, 2002**

4. *SOCIAL SECURITY NUMBER **[REDACTED]-2982** 5a. AGE—Last Birthday (Years) **53** 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Mo, Day, Yr) **Feb. 22, 1949** 7. BIRTHPLACE (City and State or Foreign Country) **Zamora Mexico**

8a. WAS DECEDENT A U.S. VETERAN? **no** 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? **none** 9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL Inpatient ER/Outpatient OOA 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 **E. Chicago** 9d. COUNTY OF DEATH **Lake**

10. MARITAL STATUS (Specify) **married** 11. SURVIVING SPOUSE (If wife, give maiden name) **Jose J. Navarro** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **homemaker** 12b. KIND OF BUSINESS/INDUSTRY **own home**

13a. RESIDENCE—STATE **Indiana** 13b. COUNTY **Lake** 13c. CITY, TOWN OR LOCATION **E. Chicago** 13d. STREET AND NUMBER **4855 Graselli St.**

13e. ZIP CODE **46312** 13f. INSIDE CITY LIMITS No Yes 13g. ON A FARM? No Yes 14. CITIZEN OF WHAT COUNTRY? **Mexico** 15. WAS DECEDENT OF HISPANIC ORIGIN? No Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) **Mexico** 16. RACE—American Indian, Black, White, etc. (Specify) **white** 17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Sec. **N/A** (0-12) College (1-4 or 5+) **N/A**

18. FATHER'S NAME (First, Middle, Last) **Jose Gutierrez** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **Carmen Leon**

20a. INFORMANT'S NAME (Type/Print) **Jose Navarro** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4855 Graselli E. Chicago In. 46312** 20c. Relationship **husband**

21a. METHOD OF DISPOSITION Burial Cremation Entombment Removal from State Donation Other (Specify) 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **March 18, 2002 Regional Cremation Services** 21c. LOCATION—City or Town, State **Munster In.**

22a. EMBALMER'S NAME **Eric Prusiecki** 22b. EMBALMER'S LICENSE NO. **ED01022431** 23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR **Eric Prusiecki** 24b. LICENSE NUMBER (of Licensee) **ED01022431** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Prusiecki Funeral Home Box J E. Chicago IN. 46312**

28. PART I. Enter the disease, 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) **Breast Cancer**

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

a. DUE TO (OR AS A CONSEQUENCE OF) **Metastases**

b. DUE TO (OR AS A CONSEQUENCE OF)

c. DUE TO (OR AS A CONSEQUENCE OF)

d.

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) 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 **Heine Ruiz, MD** 29c. MEDICAL LICENSE NO. **01046779** 29d. DATE SIGNED (Month, Day, Year) **3-15-02**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) **Heine Ruiz, M.D., 100 W. Chicago Ave, East Chicago IN 46312**

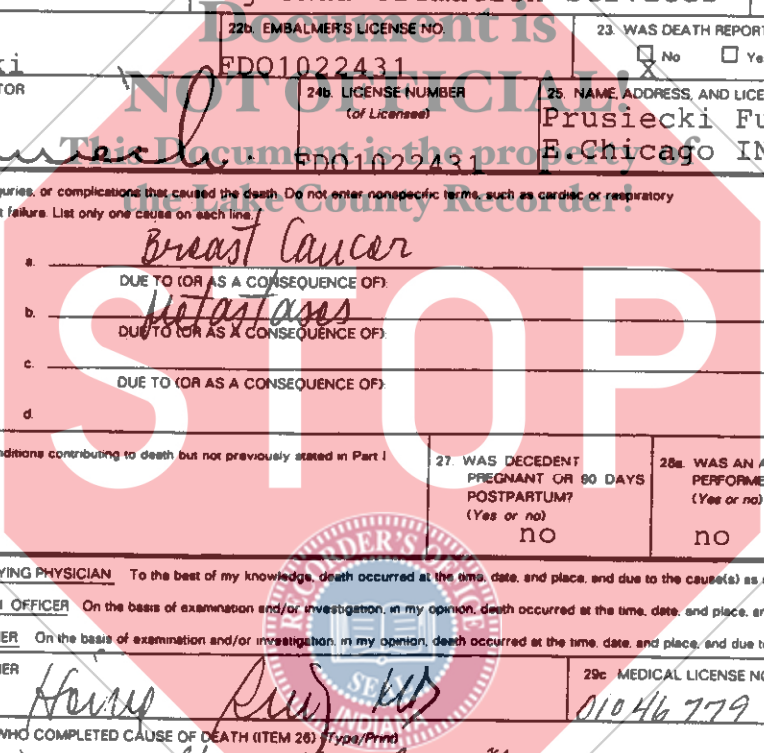
31. HEALTH OFFICER'S SIGNATURE **Dr. Timothy Prusiecki** 32. DATE FILED (Month, Day, Year) **3/18/02**

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) **FILED** 34d. DESCRIBE HOW INJURY OCCURRED **13 - EP MT**

34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) **MAR 07 2006** 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g. DATE PRONOUNCED DEAD (Month, Day, Year) 34h. MOTOR VEHICLE ACCIDENT? (Driver, passenger, pedestrian, etc.) **REGGY HOLINGA KATONA LAKE COUNTY AUDITOR 004431**



Vertical stamp: STATE OF INDIANA DEPARTMENT OF HEALTH COMMUNITY HEALTH RECORDS - 1 APR 11 11

Handwritten: K# 24-30-213-28

Handwritten: 1403LK06

**Document is
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Reference or File No.: 1403lk06

**This Document is the property of
EXHIBIT A
the Lake County Recorder!**

Lot Numbered 27 and the North ½ of Lot 28 in Block 21 as shown on the recorded plat of Calumet Addition to the City of East Chicago recorded in Plat Book 8 page 32 in the Office of the Recorder of Lake County, Indiana.

STOP



Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number in attached document.
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.

"VERIFIED FOR RECORDING BY MERIDIAN TITLE"




Signature of Declarant

Cheryl A Krepka
Printed Name of Declarant