Key # 30-454-16

*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.

Local No. 725

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Sept. 16, 2002 — Date issued
Franklin Gremuda M.D. — Hammond Health Commissioner

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): Guadalupe Rodriguez
2. SEX:
3a. TIME OF DEATH: 12:49PM
3b. DATE OF DEATH (Month, Day, Yr.): September 15, 2002
4. *SOCIAL SECURITY NUMBER: 358-20-2818
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR — Months / Days:
5c. UNDER 1 DAY — Hours / Minutes:
6. DATE OF BIRTH (Mo. Day, Yr): Jan. 13, 1925
7. BIRTHPLACE (City and State or Foreign Country): Italy Texas
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St.Margaret Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): widowed
11. SURVIVING SPOUSE (If wife, give maiden name): none
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: 4935 Indianapolis Blvd.
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [ ] No [X] 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): N/A; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): Bernabe Espinosa
19. MOTHER'S NAME (First, Middle, Maiden Surname): Hortencia De La Rosa

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Henry Rodriguez
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4935 Indianapolis Blvd.E.CHICAGO IN. 46312
20c. Relationship: son

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Calumet ParK Cemetery; September 17,2002
21c. LOCATION—City or Town, State: MerrillvilleIn.
22a. EMBALMER'S NAME: none
22b. EMBALMER'S LICENSE NO.: none
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Eric Prusiecki
24b. LICENSE NUMBER (of Licensee): FDO1022431
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Prusiecki Funeral Home P.O.Box J E.Chicago In.46312 FDH3001562

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. SEPSIS
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

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):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): no

FILED
AUG 2 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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) 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.: 01039547
29d. DATE SIGNED (Month, Day, Year): 09-16-02 (September)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): CHITTARANJAN PATEL M.D. 2075 INDIS BLVD WHITING IN.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin Gremuda M.D.
32. DATE FILED (Month, Day, Year): September 16, 2002

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.

16304

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