* **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. 0598-06

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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): Rosemary Cortopassi		2. SEX: Female	3a. TIME OF DEATH: 8:20 AM	3b. DATE OF DEATH (Month, Day, Yr.): March 9, 2006	
4. *SOCIAL SECURITY NUMBER: 339-22-9757	5a. AGE—Last Birthday (Years): 76	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo, Day, Yr): August 29, 1929	7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
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) Hospice ☐ Residence			
9b. FACILITY NAME (If not institution, give street and number): William Riley Hospice			9c. CITY, TOWN, OR LOCATION OF DEATH: Munster	9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Widowed	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): Homemeker		12b. KIND OF BUSINESS/INDUSTRY: Own Home	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Highland		13d. STREET AND NUMBER: 2245 Teakwood Circle Unit B	
13e. ZIP CODE: 46322	13f. INSIDE CITY LIMITS ☐ No ☒ Yes; 13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: USA	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): William Hurt	19. MOTHER'S NAME (First, Middle, Maiden Surname): Marie unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Kevin Cortopassi	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2245 Teakwood Cl #B,Highland,IN. 46322	20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 11, 2006 Regional Cremation Services	21c. LOCATION—City or Town, State: Munster, Indiana
22a. EMBALMER'S NAME: Phillip J. Panozzo	22b. EMBALMER'S LICENSE NO.: FD29800096	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): FD29800096	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina FH83007819 for Panozzo Bros FH 530 W 14th St, Chicago Heights,IL.604]

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. Acute Renal Failure	MONTHS
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): b. Severe arteriosclerosis	YEARS
	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)

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

MAR 10 2006

CERTIFIER

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: [signature] DO	29c. MEDICAL LICENSE NO.: 02000715	29d. DATE SIGNED (Month, Day, Year): March 10, 200

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Gerard Davidson DO, 840 Richard Drive, Dyer, Indiana 46327

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]	32. DATE FILED (Month, Day, Year): 3-10-2006

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.			

2007 033888

FILED

2007 APR 24 AM 11:56

MICHAEL A. BROWN RECORDER LAKE COUNTY

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

APR 24 2007

11290

1/LP STS

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