

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

State No. ....

Local No. 902-07

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Frank Cavato</b>				2. SEX <b>Male</b>		3a. TIME OF DEATH <b>8:07P. M</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>April 4, 2007</b>			
4. *SOCIAL SECURITY NUMBER <b>343-16-9802</b>		5a. AGE—Last Birthday (Years) <b>85</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) <b>Sept 2, 1921</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, IL</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>Unavailable</b>		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <b>XX Residence</b>							
9b. FACILITY NAME (If not institution, give street and number) <b>8226 Baring Ave.</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>				9d. COUNTY OF DEATH <b>Lake</b>			
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Rose Valco</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Personal accountant</b>				12b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>			
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Munster</b>		13d. STREET AND NUMBER <b>8226 Baring Ave.</b>					
13e. ZIP CODE <b>46321</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>	
18. FATHER'S NAME (First, Middle, Last) <b>Dominic Edward Cavato</b>						19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Veronica Talarico</b>					
20a. INFORMANT'S NAME (Type/Print) <b>Rose Cavato</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8226 Baring Ave. Munster, IN 46321</b>				20c. Relationship <b>Wife</b>			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>April 10, 2007 Heritage Crematory</b>				21c. LOCATION—City or Town, State <b>Portage, IN</b>			
22a. EMBALMER'S NAME <b>None</b>				22b. EMBALMER'S LICENSE NO. <b>NA</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Elder B...</i>				24b. LICENSE NUMBER (of Licensee) <b>FD0 1000857</b>		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>LalHayne FH 19400005 6955 South-eastern Hammond, IN for Schroeder-Lauer FH 3227 Ridge Lansing, IL 60438</b>					
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 in each line. <b>Lung Cancer</b>										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)											
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) <b>No</b>				28. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>				29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Philip Bonomi</i>								29c. MEDICAL LICENSE NO. <b>36 052056</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/07</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Philip Bonomi, MD 1725 W. Harrison Chicago, IL 60612</b>											
31. HEALTH OFFICER'S SIGNATURE <i>Sum J But...</i>										32. DATE FILED (Month, Day, Year) <b>9, 2007</b>	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide				34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)		34d. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>005645</b>	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.							