

* 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. 04-30-0350-0012

Local No. 123

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

TYPE/PRINT IN PERMANENT BLACK INK	1. DECEASED - NAME (First, Middle, Last) Juan P. Montemayor				2. SEX Male	3a. TIME OF DEATH 1:28 P	3b. DATE OF DEATH (Month, Day, Year) May 25, 2007
	4. SOCIAL SECURITY NUMBER 335-32-4305		5a. AGE - Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) April 21, 1926	7. BIRTHPLACE (City and State or Foreign Country) cd. Frontera, Coah., Mexico
DECEASED	8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES n / a		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 checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
	9b. FACILITY NAME (if not institution, give street and number) 3823 Grand Blvd.				9c. CITY TOWN OR LOCATION OF DEATH East Chicago		9d. COUNTY OF DEATH Lake
PARENTS	10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (if wife, give maiden name) Esperanza Garcia		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done most of working life. Do not use retired) Locomotive Engineer		12b. KIND OF BUSINESS INDUSTRY Steel Industry
	13a. RESIDENCE - STATE In		13b. COUNTY Lake		13c. CITY TOWN, OR LOCATION East Chicago		13d. STREET AND NUMBER 3823 Grand Blvd.
INFORMANT	13e. ZIP CODE 46312		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEASED OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Mexican
	16. RACE - American Indian, Black, White, etc. (Specify) Hispanic		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		18. FATHER'S NAME (First, Middle, Last) Melquides Montemayor		
DISPOSITION	20a. INFORMANT'S NAME (Type/Print) Esperanza Montemayor				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3823 Grand Blvd. East Chicago, IN 46312		20c. RELATIONSHIP Wife
	21a. BURIAL, CREMATION, <input type="checkbox"/> Entombment <input checked="" 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) May 30, 2007 Community Cremation			21c. LOCATION - City or Town, State Schererville, IN	
CAUSE OF DEATH	22a. EMBALMER'S NAME Henry Blake		22b. EMBALMER'S LICENSE NO. FD0109460		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
	24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of licensee) FD20700004		25. NAME AND ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Oleska-Pastrick Funeral Home FH86000155 3934 Elm St East Chicago, IN 46312		
CERTIFIER	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. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE				Approximate Interval Between Onset and Death 10 years		
	PART II. Other significant conditions - conditions contributing to death but not previously stated in Part I Severe congestive heart failure				27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No		
HEALTH OFFICER	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) <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>[Signature]</i> MD				29c. MEDICAL LICENSE NO. 1035594A		29d. DATE SIGNED (Month, Day, Year) 5-29-07
IVRA-20 (7/05)	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 25) (Type/Print) Dr. Miguel Gambetta, M.D. 10010 Don Powers Dr., Munster, IN 46321						
	31. HEALTH OFFICER SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) 5/30/07		
SDH06-004 State Form 10110-04 (R5/1-993)	33. MANNER OF DEATH <input checked="" 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) JUN 06 2007		34b. TIME OF INJURY		
	34c. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		34d. LOCATION (Street and Number or Rural Route Number City or Town, State) 11935				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT (Yes or No) If yes, specify driver, passenger or pedestrian, etc.				

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT