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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

new # PA 323/VA 9441-20

CERTIFICATE OF DEATH

State No. 15-23-40

Local No. 1965-04

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) KAREN A. PRUZIN		2. SEX Female	3a. TIME OF DEATH 5:05 AM	3b. DATE OF DEATH (Month, Day, Yr.) August 7, 2004
4. *SOCIAL SECURITY NUMBER 310-68-3047	5a. AGE—Last Birthday (Years) 47	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) March 24, 1957
7. BIRTHPLACE (City and State or Foreign Country) Aberdeen, Scotland	8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)
9b. FACILITY NAME (If not institution, give street and number) St. Anthony Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Thomas G. Pruzin	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 Crown Point		13d. STREET AND NUMBER 755 Seminole Court
13e. ZIP CODE 46307	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		18. FATHER'S NAME (First, Middle, Last) Herbert Garden		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret E. Horne			20a. INFORMANT'S NAME (Type/Print) Thomas G. Pruzin	
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 755 Seminole Ct, Crown Point, IN 46307		20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) August 11, 2004 Maplewood Memorial Cemetery		21c. LOCATION—City or Town, State Crown Point, Indiana
22a. EMBALMER'S NAME Jonathon R. Christiansen		22b. EMBALMER'S LICENSE NO. FD20200095	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) 1009893	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410	
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. Vascular collapse		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		
IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to arteriosclerotic heart and vascular disease		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		29. CERTIFIER (Check only one) Deputy <input 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 checked="" 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>		29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month, Day, Year) August 9, 2004	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Paul R. Castro, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) August 11, 2004		
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)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED. DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.		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) August 7, 2004		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		34i. [Handwritten: 21470A]		

