

* 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. 24-30-484-0016

Local No. 70

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

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DECEDENT

PARENTS

INFORMANT

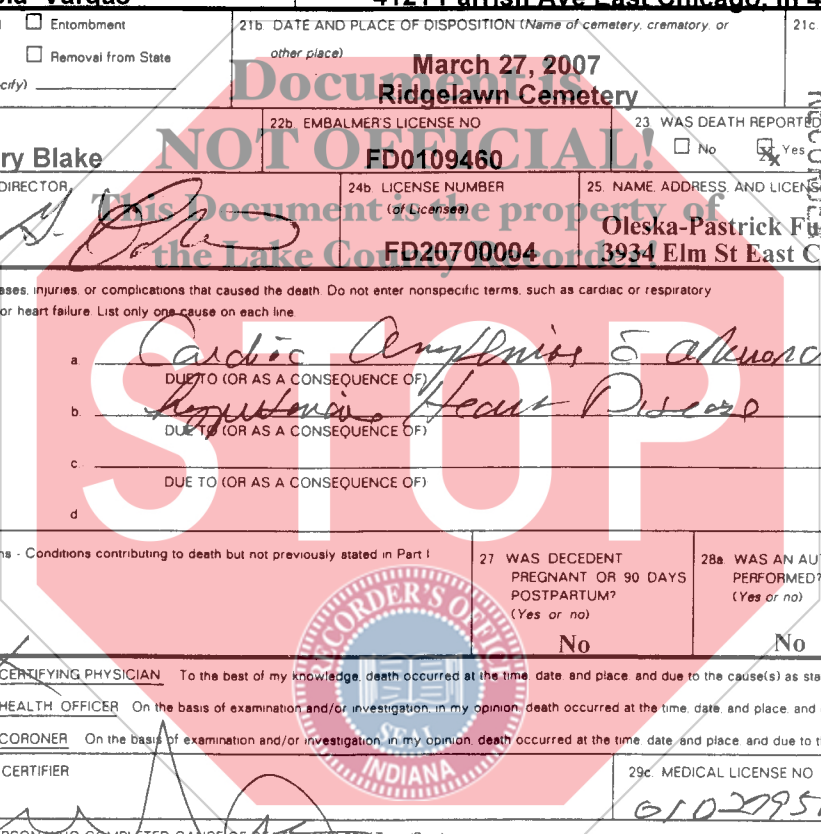
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Clara Vargas				2 SEX Female	3a TIME OF DEATH 7:30 A M	3b DATE OF DEATH (Month, Day, Yr) March 22, 2007	
4 *SOCIAL SECURITY NUMBER 312-92-7167		5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) April 30, 1936		7 BIRTHPLACE (City and State or Foreign Country) Camuy, Puerto Rico
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		9a PLACE OF DEATH (Check only one See instructions) <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) 4121 Parrish Ave				9c CITY, TOWN OR LOCATION OF DEATH East Chicago		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Luis M Vargas		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 Home	
13a RESIDENCE—STATE In		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION East Chicago		13d STREET AND NUMBER 4121 Parrish Ave	
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 DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Puerto Rican	
16 RACE—American Indian, Black, White, etc. (Specify) Hispanic		17 DECEDENT'S EDUCATION (Specify only highest grade completed) N/A		18 FATHER'S NAME (First, Middle, Last) Ramon Adorno			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Alejita Rodriguez				20a INFORMANT'S NAME (Type/Print) Alicia Vargas		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4121 Parrish Ave East Chicago, In 46312	
20c Relationship Daughter				21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) March 27, 2007 Ridgelawn Cemetery	
21c LOCATION (City or Town, State) Gary, In				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 Licenses) FD20700004		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Oleska-Pastrick Funeral Home FH86000155 3934 Elm St East Chicago, IN 46312	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a Cardiac Arrhythmias & Altered Rhythms DUE TO (OR AS A CONSEQUENCE OF) b Septicemic Heart Disease 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				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) 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>	
29c MEDICAL LICENSE NO. 61029951A				29d DATE SIGNED (Month, Day, Year) 4/10/07		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) Y. M. Kim 4035 Elm St East Chicago, In. 46312	
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) 4/10/07		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 18 2007		34b TIME OF INJURY		34c INJURY (Yes or no) DESCRIBE HOW INJURY OCCURRED PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR 1-2088			
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) LAKE COUNTY AUDITOR		34e 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.				34i			



2007 JUN 18 PM 1:07
STATE OF INDIANA
FILED
MICHAEL J. BROWN
RECORDER'S OFFICE
EAST CHICAGO, IN