

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

key# (24) 30-614-18

Local No. 11679-92

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

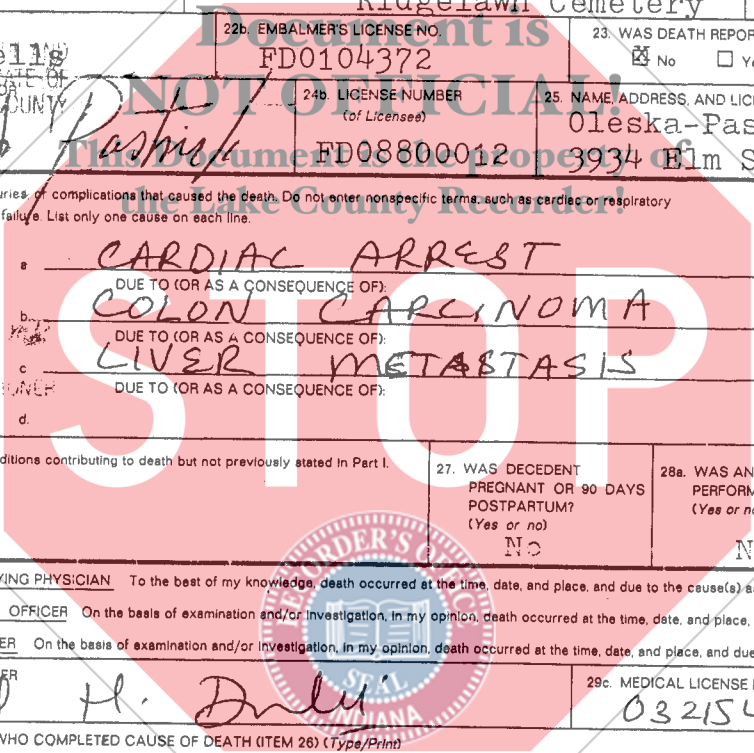
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) Olivia G. Rodriguez		2. SEX female	3. TIME OF DEATH 10:05 p.m.	3b. DATE OF DEATH (Month, Day, Yr.) August 6, 1992	
4. SOCIAL SECURITY NUMBER 463-50-7634	5a. AGE—Last Birthday (Years) 2008	5b. UNDER 1 YEAR 046030	5c. UNDER 1 DAY Hours: 20 Minutes: 2	6. DATE OF BIRTH (Mo, Day, Yr.) Feb. 24, 1923	
7. BIRTHPLACE (City and State or Foreign Country) Texas	8a. WAS DECEDENT 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"/> Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) Munster Med-Inn		9c. CITY, TOWN, OR LOCATION OF DEATH Munster	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Ovidio Rodriguez	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 Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION East Chicago	13d. STREET AND NUMBER 2304 Purdue Drive		
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.) Mexican-American	16. RACE—American Indian, Black, White, etc. (Specify) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) N/A		18. FATHER'S NAME (First, Middle, Last) Miqueas Guillen			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Paula Garcia		20a. INFORMANT'S NAME (Type/Print) Ovidio Rodriguez			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Purdue Dr. East Chicago, IN		20c. Relationship Husband			
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) August 10, 1992 Ridgelawn Cemetery		21c. LOCATION—City or Town, State Gary, Indiana	
22a. EMBALMER'S NAME Charles W. Wells		22b. EMBALMER'S LICENSE NO. FD0104372		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR David J. Pasnik		24b. LICENSE NUMBER (of Licensee) FD08800012		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Oleska-Pastrick Funeral Home #155 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. List only one cause on each line. AUG 10 1992 IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. COLON CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): c. LIVER METABTASIS 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		28c. 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 Paul H. Doshi			29c. MEDICAL LICENSE NO. 032154	29d. DATE SIGNED (Month, Day, Year) 8/8/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. P. Doshi, M.D., 7905 Calumet Avenue, Munster, IN 46321					
31. HEALTH OFFICER'S SIGNATURE Alexander Williams, MD			DATE FILED (Month, Day, Year) Aug. 10, 1992		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 JUN 24 2000
34a. 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) PEGGY HULINGA KATONA LAKE COUNTY AUDITOR		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



FILED

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