## INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Level No. 112.0	-08									•		
1. Decedent's Legal Name (First, Middle, Last) 1a. I				a. Maiden Last Name (If Female)			2. Sex	Stat 3. Time O	of Death Date Of Death (Month/Day/Year)			
Sara Mansueto  5. Social Security Number   6a. Age - Yrs   6b. Under 1 Year   6c. Under 1 Montr			Sm 0	ert			Female 8:3		BOPM Pril		1, 200	
217-28 -0080 76 Months	Days		Hours				of Birth (Month/Day/Year) The 26, 1932		8. Birthplace (City All Salte Or Foreign Philadelphia, F			
9. Ever In U.S. Armed Forces? 10. If Death Occurre  ☐ Yes ☐ No Unknown ☐ ☐ Inpatient ☐ Em	ad On Arrival	10a. If Death Occurred Somewhere Other Than A Hospital:  ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Hom				All and Torm Cox Excility (Cox 14)						
11. Facility Name (If Not Institution, Give Street And Number	)	очравен 🗀 ос	ad Oli Alli Vali	1 1035	cc i acinty - Ed - De	ecedent 5 FIOI	THE LITHUISHING FLOR	nercong-Terr	Care Facility	La vitter (Specify)		
1328 Park Dr.  12. City Or Town, State, And Zip Code					13. County Of Death				14. Marital Status At Figne Of Death			
Munster, IN 46321				Lake				Ç	Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown			
15. Surviving Spouse's Name Dr. Mario Mansueto		15a. (If Wife)Give		16. Decedent's Usual Occupation Registered Nurse			1	17. Kind Of Business/Industry Medical				
18. Residence – State	·	18b. City Or Town										
IN	Lake			Munster					~			
18c. Street And Number								pt. No. 18e. ZipCede 1 181, Inside City Limits?				
1328 Park Dr.  19. Decedent's Education L 20. Decedent Of Hispanic Orgin									46321 TYPES ONO			
12/5	edent Of Hispanic	Origin	21. Decedent's Race White					SP 2 TAG				
22. Father's Name (First, Middle, Last)	INO		23. Moth	WNICE Mother's Name (First, Middle, Last)				23a. Mother's Maiden Last Name				
James Kane Smart				Angela Smart				20	S Getty			
Dr. Mario Mansueto Husband			Decedent	24b. Mailing Address (Street And Number, Cit 1328 Park Dr. Mi					<del>⊆ ' ⇔</del> 463 <b>2</b> ],	3	"W	
25a. Method Of Disposition		Do	25. Pl	ace Of Dis	position				Manage .			
### Buriat   Cremation   Donation   Entombment   Removal From State   Other (Specify):	Assumpt i	ion Cem		FI(	CIA		- City, Town, And S			27a. Funeral H		
□Yes XiNo Burns-	Kish Fu		ment ome 84	15 C	lumet	Ave.	Munster	IN 4	46321	300496		mber:
27b. Signature Of Indiana Funeral Service Licensee.	2 un	e Lak	e Cou	nty I	tecor	der!	27c. License 10451		icensee):			
28. Part I. Enter The Chain Of Events—Diseases, Such As Cardiac Arrest, Respiratory Arrest, Or Ver A Line. Add Additional Lines If Necessary.  Immediate Cause (Final Disease Or Condition Res	tricular Fibrillation	plications—Tha n Without Show	ring The Etiology	d The Dea	oth, Do Not Er Abbreviate. E	nter Termini inter Only C	al Events One Cause On	0/	7		Approxima Interval: C To Death	
Sequentially List Conditions, If Any, Leading To The Line A. Enter The Underlying Cause (Disease Or In The Events Resulting In Death) Last  Part II. Enter Other Significant Conditions Contributing To De	njury That Initiated	c _			D.		onsequence Of):					
Metastani to brain, I	ine. In	y iii Tile Underlyin	g Cause Given In P	R'S	1 1		riopsy Performed? psy Findings Availa	ble To Comp	es D No lete The Cause	Of Death?	Yes No	lo.
31. Did Tobacco Use Contribute To Death?	32 If Female:	,	(C.O					ner Of Death		<u>L</u>		
1	Not Pregnant Within F Not Pregnant, But Pre	Past Year Pregnar	nt At Time Of Death Cear Before Death	Not Pregnant Unknown if Pr	, But Pregnant Within egnant Within The F	in 42 Days Of De		☐ Homicide	☐ Accident ☐	ending Investigation		
	35. Time Of Injury		36. Pia	ce Of Injury	(E.G., Decedent	's Home, Con	struction Site, Rest	Could Not	ded Area)	37. Injur	y At Work?	
	8a. City Or Town	0-	38b. S	Tecs No	ber 9	n			38c. Apt. No		′es □ No ode	
39 Describe How Injury Occurred		0206	7>	JUN	26 20	008			on Injury, Specif	y: Pedestrian  Other (\$	Specify)	
41. Signature, Of Person Certifying Cause Of Death:			PEG	GY H	OLINGA	KATC	Certifier (Check O	nly One)				<del></del>
43. Name, Address And Zip Code Of Person Certifying Cause Of Death:					Y HOLINGA KATONA (12. Certifier (Check Only One)  COUNTY AUDITOR 44. License Number 45. Date Certified							
J. Walsh, MD 9122 Colu			ster,IN						27487	_	3 ,200	08
46. Additional Funeral Service Provider:								. *Akas:	U/1U/	1.15.11	1	
48. Signature of Local Health Officer:	26	Sent	D.O.			49.	For Registrar Onl	ly - Date File	d (Month/Day/\	rear):	HM5	394

State Form 10110 (R7/9-07) ATTIFFTION ESTATE. The Social Security # is being requested by this state agency in order to cursue its statutory responsibility. Disclosure is voluntary and there will be no behalfly for refusal. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-11.