* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 1321-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): Cecelia D. Raven
2. SEX: Female
3a. TIME OF DEATH: 4:57 pm
3b. DATE OF DEATH (Month, Day, Yr.): May 23, 2007
4. *SOCIAL SECURITY NUMBER:
5a. AGE - Last Birthday (Years): 78
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): April29,1929
7. BIRTHPLACE (City and State or Foreign Country): Chicago Illinois
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
PLACE OF DEATH (Check only one See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY HOSPICE
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
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: AT HOME
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 301 Cedar Street
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): Elementary/Secondary (0-12): 10; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN MUSALO
19. MOTHER'S NAME (First, Middle, Maiden Surname): FELINIA OSEVICH

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Alice I. Raven
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 Cedar Street, Crown Point, IN 46307
20c. Relationship: DAUGHTER

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 26, 2007 Northwest Indiana Cremation
21c. LOCATION - City or Town, State: Crown Point, Indiana
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F. Burns
24b. LICENSE NUMBER (of Licensee): FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FH83002445 10101 Broadway,Crown Point,Indiana

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Ovarian Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last
c.
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
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

CERTIFIER

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: [signature] MD
29c. MEDICAL LICENSE NO.: 01061783A
29d. DATE SIGNED (Month, Day, Year): 5/25/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/Print): DR. ERIN VICARI, 2050 MAIN ST., SUITE F, CROWN POINT, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W. [signature] D.O.
32. DATE FILED (Month, Day, Year): May 25, 2007

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
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):
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

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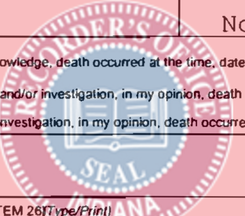
SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1


FILED
MAR 05 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR
2010 021768
FILED FOR RECORD
2010 MAR -5 PM 3:37
MICHELLE R. FAJMAN
RECORDER
MAR 05 2010