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.

Local No. 848-04

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 45-07-30-179-001-000027

33531

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First Middle Last)	JAMES P. DELLAROCCO
2. SEX	MALE
3a. TIME OF DEATH	2:55 A.M
3b. DATE OF DEATH (Month Day Year)	MARCH 28, 2004
4. SOCIAL SECURITY NUMBER	310-42-9104
5a. AGE—Last Birthday (Years)	64
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	June 20,1939
7. BIRTHPLACE (City and State or Foreign Country)	East Chicago,IN
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN US ARMED FORCES?	None
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	THE COMMUNITY HOSPITAL
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)	Yvonne Baltrus
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Civil Engineer
12b. KIND OF BUSINESS/INDUSTRY	Construction
13a. RESIDENCE—STATE	IN
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Munster
13d. STREET AND NUMBER	1110 Bluebird Dr.
13e. ZIP CODE	46321
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12 / 5+

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	James Dellarocco
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Clarene DaPra

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Yvonne Dellarocco
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1110 Bluebird Dr. Munster,IN 46321
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	March 31, 2004 St. Joseph Cemetery
21c. LOCATION—City or Town, State	Hammond,IN
22a. EMBALMER'S NAME	Kevin W. Kish
22b. EMBALMER'S LICENSE NO	1021590
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	1021590
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home#3004968 8415 Calumet Munster, IN 46321

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. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiac [illegible]
DUE TO (OR AS A CONSEQUENCE OF):
c. End Stage Renal Disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Diabetes Mellitus

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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)

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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]

29c. MEDICAL LICENSE NO 02000848A

29d. DATE SIGNED (Month Day Year) MARCH 31 2004

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
STEVEN MISCHEL, D.O. 222 DOUGLAS STREET HAMMOND, INDIANA 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE [signature]

32. DATE FILED (Month, Day, Year) April 1, 2004

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) Specify if driver, passenger, pedestrian, etc.

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2010 DEC 17 AM 9:45 FILED FOR RECORD

FILED DEC 17 2010 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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SDH 06-004 State Form 10110 (R5/1-93)

OFFICE OF THE LAKE COUNTY RECORDER

LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, INDIANA 46307

MICHELLE R. FAJMAN
Recorder

PHONE (219) 755-3730
FAX (219) 755-3257

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CUSTOMER INITIALS: _____ **DATE:** _____/_____/_____

EMPLOYEE INITIALS: MH **DATE:** 12/29/10