

45-03-27-254-017.000-024

\* 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. ....

Local No. .... 297

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH COMMUNITY TITLE COMPANY FILE NO L 44364

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>Joseph Gonzales</b>		2 SEX <b>male</b>	3a TIME OF DEATH <b>1:23P M</b>	3b DATE OF DEATH (Month, Day, Yr) <b>November 8, 2000</b>	
4 *SOCIAL SECURITY NUMBER <b>314-20-0383</b>	5a AGE—Last Birthday (Years) <b>74</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>March 1, 1926</b>	
7a BIRTHPLACE (City and State or Foreign Country) <b>MESA, (Unknown) Arizona</b>	7b PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				
8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>	9a FACILITY NAME (if not institution, give street and number) <b>The 4360 Lane of Roses</b>			
9b FACILITY NAME (if not institution, give street and number) <b>The 4360 Lane of Roses</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>East Chicago</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>married</b>	11 SURVIVING SPOUSE (if wife, give maiden name) <b>Helen Ruiz</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Brick Mason</b>		12b KIND OF BUSINESS/INDUSTRY <b>Steel Manufacturing</b>	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>	13c CITY, TOWN, OR LOCATION <b>East Chicago</b>		
13d STREET AND NUMBER <b>4360 Lane of Roses</b>		13e ZIP CODE <b>46312</b>			
13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify) <b>white</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		18 DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) <b>Claro Gonzales</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marina Alviso</b>			
20a INFORMANT'S NAME (Type/Print) <b>Helen Gonzales</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4360 Lane of Roses, East Chicago, Indiana 46312</b>		20c Relationship <b>wife</b>	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>November 13, 2000 Regional Cremation Services</b>		21c LOCATION—City or Town, State <b>Munster, Indiana</b>	
22a EMBALMER'S NAME <b>NONE</b>		22b EMBALMER'S LICENSE NO. <b>n/a</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Paul A. Ketter</i>		24b LICENSE NUMBER (of License) <b>FDO8601585</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9039 Kleinman Road Highland, Indiana 46322 FH83007500</b>		
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. <b>Carcinoma of the pancreas</b>					
26 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) <b>no</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>no</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>n/a</b>	
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>Barbara L. Fuller, MD</i>		29c MEDICAL LICENSE NO. <b>01034701</b>	29d DATE SIGNED (Month, Day, Year) <b>11/09/00</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Barbara L. Fuller, MD, 930 S So. Calumet Ave Ste A, Munster, IN 46322</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Helen Zinnothy Kayserwick</i>			32 DATE FILED (Month, Day, Year) <b>11-13-00</b>		
33 MANNER OF DEATH <input 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)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED <b>AMOUNT \$ CASH CHARGE CHECK # CM COPY 026623</b>
34a PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34d LOCATION (Street, Rural Route Number, City or Town, State)			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE OCCUPANT (Yes or no) If yes, specify driver, passenger, etc.			

FILED MAY 06 2011 PEGGY HOLLINGA KATONA LAKE COUNTY AUDITOR