





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

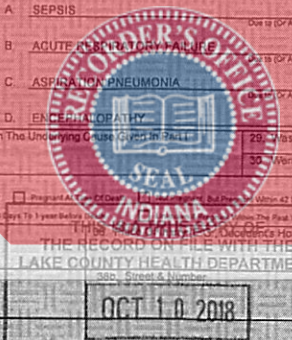
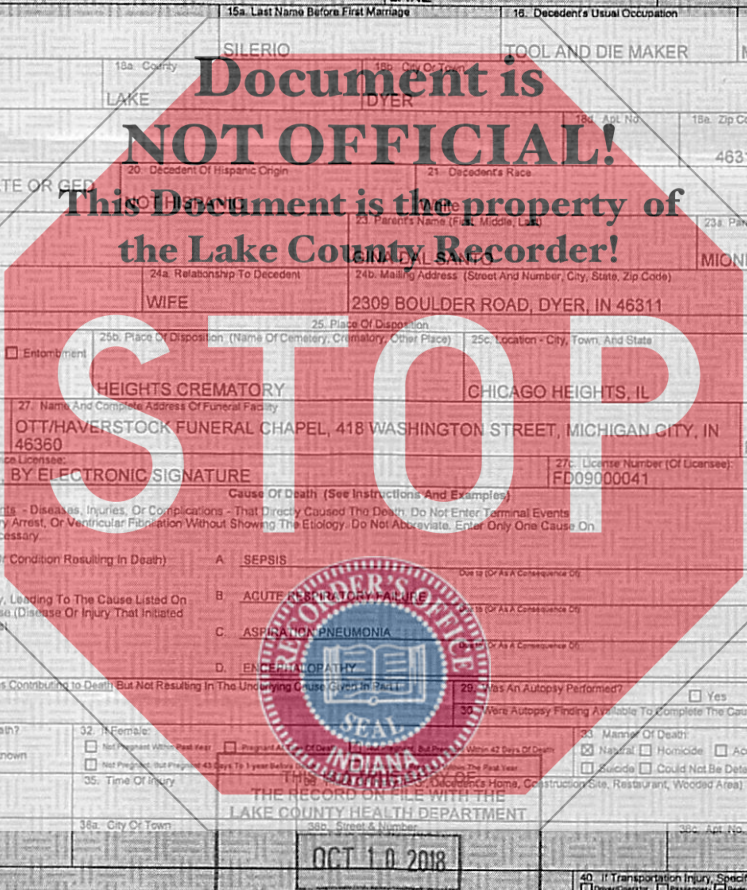
Tracking No. 173120

Local No 903339

EDR No 00000668422

State No 049031

1. Decedent's Legal Name (First, Middle, Last) <b>BRUNO ANTONIO DAL SANTO</b>				1a. Maiden Name (if female)		2. Sex <b>MALE</b>		3. Time of Death <b>09:15 AM</b>		4. Date of Death (Month/Day/Year) <b>09/27/2018</b>					
5. Social Security Number <b>[REDACTED]</b>		6a. Age - Yrs <b>68</b>		6b. Under 1 Year Months: <b>03</b> Days: <b>22</b> Hours: <b>00</b> Minutes: <b>00</b>		7. Date of Birth (Month/Day/Year) <b>03/22/1950</b>		8. Birthplace (City and State or Foreign Country) <b>UNAVAILABLE, IT</b>							
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival		10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)											
11. Facility Name (If Not Institution, Give Street and Number) <b>FRANCISCAN HEALTH - DYER</b>										12. City Or Town, State, And Zip Code <b>DYER, IN, 46311</b>		13. County Of Death <b>LAKE</b>		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name <b>MARTHA DAL SANTO</b>				15a. Last Name Before First Marriage <b>SILERIO</b>		16. Decedent's Usual Occupation <b>TOOL AND DIE MAKER</b>		17. Kind Of Business/Industry <b>MACHINIST</b>							
18a. Residence - State <b>INDIANA</b>		18b. Country <b>LAKE</b>		18c. City Or Town <b>DYER</b>		18d. Apt. No.		18e. Zip Code <b>46311</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
15c. Street And Number <b>2309 BOULDER ROAD</b>		19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>		20. Decedent Of Hispanic Origin <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. Decedent's Race <b>WHITE</b>									
22. Parent's Name (First, Middle, Last) <b>LINO DAL SANTO</b>				23. Parent's Name (First, Middle, Last) <b>MARIE DAL SANTO</b>		23a. Parents' Last Name Before First Marriage <b>MIONI</b>									
24. Informant's Name <b>MARTHA DAL SANTO</b>				24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>2309 BOULDER ROAD, DYER, IN 46311</b>									
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>HEIGHTS CREMATORY</b>		25c. Location - City, Town, And State <b>CHICAGO HEIGHTS, IL</b>		26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>OTT/HAVERSTOCK FUNERAL CHAPEL, 418 WASHINGTON STREET, MICHIGAN CITY, IN 46360</b>		27a. Funeral Home License Number <b>FH88800023</b>					
27b. Signature Of Indiana Funeral Service Licensee <b>PATRICK W REYNOLDS BY ELECTRONIC SIGNATURE</b>				27c. License Number (Of Licensee) <b>FD09000041</b>		28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) <b>A. SEPSIS</b> Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last. <b>B. ACUTE RESPIRATORY FAILURE</b> <b>C. ASPHYXIA PNEUMONIA</b> <b>D. ENCEPHALOPATHY</b>		Approximate Interval: Onset To Death <b>FEW DAYS</b> <b>FEW WEEKS</b> <b>FEW WEEKS</b> <b>FEW WEEKS</b>							
28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause (Given In Part I) <b>END STAGE RENAL DISEASE</b>				29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Was Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within 43 Days Prior To Death <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Pregnant, But Not Within 42 Days Of Death		33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Location Of Injury - State		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
36. Location Of Injury - State		36a. City Or Town		36b. Street And Number		36c. Apt. No.		36d. Zip Code		39. Describe How Injury Occurred					
41. Signature, Of Person Certifying Cause Of Death: <b>ASIF H. FAROOQUI, BY ELECTRONIC SIGNATURE</b>				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		44. License Number <b>01063801A</b>		45. Date Certified <b>10/03/2018</b>							
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>ASIF H. FAROOQUI, 8020 KNUE RD., INDIANAPOLIS, IN 46250</b>				46. Additional Funeral Service Provider <b>PLANET GREEN CREMATIONS INC</b>		47. *AXIS		48. Signature of Local Health Officer <b>CHANDANA VAVILALA, VIA ELECTRONIC SIGNATURE</b>							
49. For Registrar Only - Date Filed (Month/Day/Year) <b>OCT 09 2018</b>				AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)											



NOT VALID UNLESS



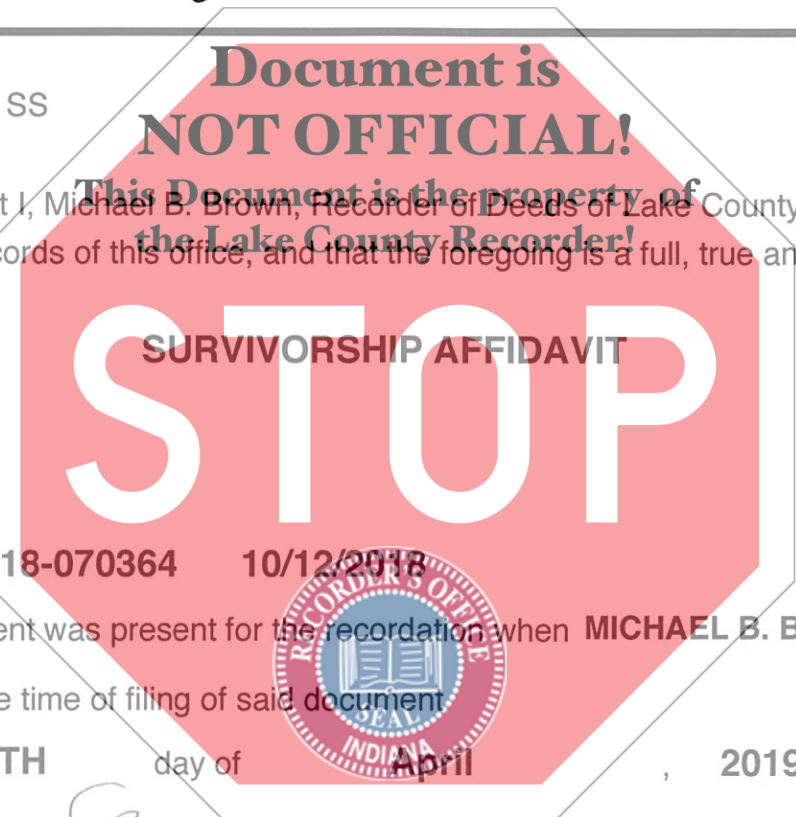
**Michael B. Brown**

**Recorder of Deeds  
Lake County Indiana  
2293 North Main Street  
Crown Point, IN 46307  
219-755-3730**

# Certification Letter

State of Indiana )  
County of Lake ) SS

This is to certify that I, Michael B. Brown, Recorder of Deeds of Lake County, Indiana am the custodian of the records of this office, and that the foregoing is a full, true and complete copy of a



as recorded as **2018-070364** **10/12/2018**  
as this said document was present for the recordation when **MICHAEL B. BROWN**  
was Recorder at the time of filing of said document

Dated this **18TH** day of **April**, **2019**

*Coverly H. Bridgeman*  
Deputy Recorder

*Michael B. Brown*  
Michael B. Brown, Recorder of Deeds  
Lake County Indiana



Form # 0023 Revised 5/2002