

NOT AN OFFICIAL DOCUMENT

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Tracking No. 278865



Local No 001915

EDR No 000011098497

State No 2021-025746

1. Decedent's Legal Name (First, Middle, Last) Rafael J. Marciano		2. Gender Male		3. Time of Death 09:51 AM		4. Date of Death (Month/Day/Year) 04/16/2021	
5. Social Security Number 27		6a. Under 1 Year Months 27		6b. Under 1 Month Days 27		6c. Under 1 Day Hours 27	
7. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		8. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival		9. 7. 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):		10. 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) St. Mary Medical Center Hobart				12. City or Town, State, and Zip Code Hobart, Indiana 46342		13. County of Death Lake	
14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown		15. Surviving Spouse's Name		16. Last Name Before First Marriage		17. Decedent's Usual Occupation Unavailable	
18. Residence - State IN		19a. County Lake		19b. City or Town Hobart		18. Decedent's Usual Occupation Unavailable	
18c. Street and Number 3816 Swift Street		18d. Apt. No.		19c. Zip Code 46342		19d. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education High School graduate or GED completed		20. Decedent Of Hispanic Origin Hispanic		21. Decedent's Race White		22. Parent's Name (First, Middle, Last) José Rafael Marciano	
23. Parent's Name (First, Middle, Last) José Rafael Marciano		24. Parent's Name (First, Middle, Last) Jacinta M. McMaster		25. Parent's Last Name Before First Marriage Ring		26. Informant's Name Elizabeth Ring	
27. Relationship To Decedent Grandmother		28. Mailing Address (Street And Number, City, State, Zip Code) 145 S Delaware Street, Hobart, IN, 46342		29. Place Of Disposition Kelly-Carroll Cremation Service		30. Location - City, Town, And State Gary, IN	
31. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		32. Name And Complete Address Of Funeral Facility Rees Funeral Home Hobart Chapel 600 W Old Ridge Road, Hobart, Indiana, 46342		33. Funeral Home License Number FH83003069		34. Signatory Of Indiana Funeral Service License: Justus R. Frase	
35. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Conial on <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		36. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) Kelly-Carroll Cremation Service		37. Location - City, Town, And State Gary, IN		38. License Number Of Licensee FD29700036	
39. Part I: Enter The Chain Of Events - Disease, Injury, 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): A. Exsanguination B. Multiple (5) incised Wounds C. Sequentially Lip Conditions, 8 Any, Leading To The Cough Listed On Line A. Enter The Underlying Cause (Disease Or Injury) That Initiated The Events Resulting In Death) Last D. Multiple (5) incised Wounds		40. Was An Autopsy Performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		41. Were Autopsy Findings Available To Complete The Cause Of Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		42. Manner Of Death (See Instructions And Examples) Immediate	
43. Part II: Enter Other Significant Conditions Contributing To Death but Not Resulting in The Underlying Cause Given in Part I		44. Was An Autopsy Performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		45. Were Autopsy Findings Available To Complete The Cause Of Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		46. Approximate Interval, Onset To Death Immediate	
47. Did Toxicology Ever Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		48. 32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Pregnant, But Pregnant 43-90 Days After Time Of Death <input type="checkbox"/> Unknown If Pregnant Within Past Year		49. 33. Manner Of Death: <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		43. Date Of Injury (Month/Day/Year) 04/16/2021	
50. Date Of Injury (Month/Day/Year) 04/16/2021		51. Time Of Injury 08:59 AM		52. Place Of Injury (If E.G., Decedent's Home, Construction Site, Restaurant, Woods, Area) St. Mary Medical Center		53. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
54. Location Of Injury - State Indiana		55. City or Town Hobart		56. Street & Number 3816 Swift Street		57. City or Town 46342	
58. Describe How Injury Occurred Multiple Incised Wounds		59. Signature Of Person Certifying Cause Of Death Merrilee D. Fry		60. Certifier (Check Only One) <input type="checkbox"/> Coroner <input checked="" type="checkbox"/> Health Officer		61. License Number 05/12/2021	
62. Name, Address And Zip Code Of Person Certifying Cause Of Death Merrilee D. Fry 2900 W 93rd Avenue, Crown Point, IN 46307		63. Signature of Local Health Officer Cheranda Varela		64. Registrar Only - Date (Month/Day/Year) 05/12/2021		65. Date Contacted 05/12/2021	

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)