INDIANA STATE BOARD OF HEALTH

92-013962

Local No. 0878-92

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last): Marie A. Gilboe			2. SEX: Female	3a. TIME OF DEATH: 6:58 pM	3b. DATE OF DEATH (Month, Day, Yr.): April 18, 1992
5a. AGE—Last Birthday (Years): 91	5b. UNDER 1 YEAR: Months Days	5c. UNDER 1 DAY: Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr): November 29, 1900	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? -----	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA	OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence		

DECEDENT

9b. FACILITY NAME (If not institution, give street and number): Munster Community Hospital	9c. CITY, TOWN, OR LOCATION OF DEATH: Munster	9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Widowed	11. SURVIVING SPOUSE (If wife, give maiden name): ----------	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Kitchen	12b. KIND OF BUSINESS/INDUSTRY: Rand McNally
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Hammond	13d. STREET AND NUMBER: 254 Locust Street

13e. ZIP CODE: 46324	13f. INSIDE CITY LIMITS: ☐ No ☒ Yes	13g. ON A FARM: ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY: U.S.A.	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): 8 Yrs; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Levanowski	19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna N/A

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Thomas Gilboe	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P O Box 1642, Highland, Indiana 46322	20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 22, 1992 Calvary Cemetery	21c. LOCATION—City or Town, State: Portage, Indiana

22a. EMBALMER'S NAME: James Porras	22b. EMBALMER'S LICENSE NO.: 1045964	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: Brian T Burns	24b. LICENSE NUMBER (of Licensee): 8601763	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #3002819, 5840 Hohman Ave, Hammond, 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.	ACUTE MYOCARDIAL INFARCTION	
DUE TO (OR AS A CONSEQUENCE OF) b.	CONGESTIVE HEART FAILURE	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF) 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))	28a. WAS AN AUTOPSY PERFORMED? (Yes or (No))	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or (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: R Kansal MD	29c. MEDICAL LICENSE NO.: IN 01038984	29d. DATE SIGNED (Month, Day, Year): 4/20/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. R. Kansal, 9495 Keilman, St. John, Indiana

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander Williams, M.D.	32. DATE FILED (Month, Day, Year): April 20, 1992

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide	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.			