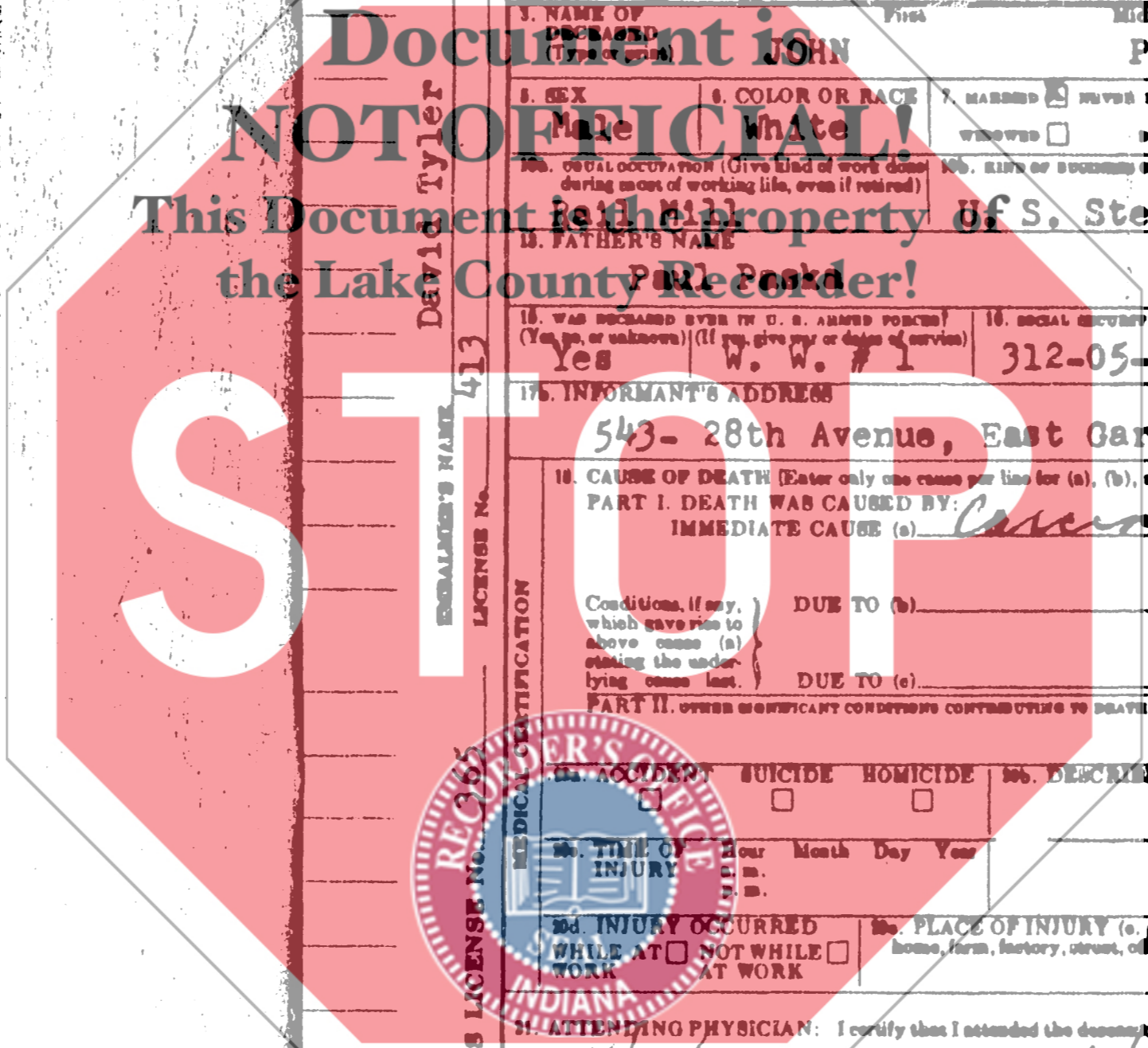


7775

INDIANA STATE BOARD OF HEALTH 1st Sub. East Gary
DIVISION OF VITAL RECORDS State Lots 1 & 2 Bl.3
MEDICAL CERTIFICATE OF DEATH

Local No. 66-1205 3rd 7775

1. PLACE OF DEATH a. COUNTY <u>Lake</u>		1. USUAL RESIDENCE (When deceased lived in institution, residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Lake</u>	
b. CITY, TOWN, OR LOCATION <u>Gary</u>		c. Length of Stay in 1b <u>East Gary</u>	
d. NAME OF HOSPITAL OR INSTITUTION <u>Methodist Hospital</u>		d. STREET ADDRESS <u>543- 28th Avenue</u>	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>JOHN PASKA</u>		f. DATE OF DEATH Month Day Year <u>Nov. 29, 1966</u>	
8. SEX <u>Male</u> 8. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <u>79</u>		9. DATE OF BIRTH <u>Oct. 23, 1887</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign territory) <u>Czecho-slovakia</u>	
12. FATHER'S NAME <u>P. P. Paska</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give pay or date of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> <u>W. W. # 1</u>		16. SOCIAL SECURITY NO. <u>312-05-1816</u>	
17. INFORMANT'S NAME <u>Margaret Paska</u>		18. RELATIONSHIP TO DECEASED <u>Wife</u>	
19. INFORMANT'S ADDRESS <u>543- 28th Avenue, East Gary, Indiana</u>		19. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular oxygen embolism</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TRIMORPHIC CAUSE (a), (b), or (c). DUE TO (b) _____ DUE TO (c) _____			
19. ACCIDENT SUICIDE HOMICIDE 20. DESCRIBE HOW INJURY OCCURRED. (State nature of injury in Part I or Part II of item 18.)			
21. TIME OF INJURY Hour Month Day Year			
22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
23. CITY, TOWN, OR LOCATION COUNTY STATE			
24. ATTENDING PHYSICIAN: I certify that I attended the deceased from <u>4/20/54</u> to <u>11/29/66</u> and last saw him alive on <u>11/29/66</u> . Death occurred at <input type="checkbox"/> N.E.T. <input type="checkbox"/> C.B.T. on the date stated above; and to the best of my knowledge, from the cause stated <input type="checkbox"/> N.E.T. <input type="checkbox"/> C.B.T.			
25. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at <input type="checkbox"/> N.E.T. <input type="checkbox"/> C.B.T. from causes stated and on above date.			
26. Signature of Attending Physician or Health Officer <u>Samuel D. Brown MD</u>		26. ADDRESS <u>3290 Grand</u>	
27. DATE SIGNED <u>DEC 1 1966</u>		27. DATE SIGNED <u>12/1/66</u>	
28. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		28. NAME OF CEMETERY OR CREMATORY <u>Calumet Park Cemetery</u>	
29. DATE REC'D BY LOCAL HEALTH OFFICER <u>DEC 1 1966</u>		29. LOCATION <u>Crown Point, Indiana</u>	
30. SIGNATURE OF HEALTH OFFICER <u>[Signature]</u>		30. FUNERAL DIRECTOR <u>Geison Funeral Home, Inc., Gary, Ind</u>	



EXAMINER'S NAME Tyler Davis
 LICENSE NO. 413
 MEDICAL CERTIFICATION
 FUNERAL DIRECTOR'S LICENSE NO. [blank]

Permit
Date

7775

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NOT OFFICIAL!

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the Lake County Recorder!



STATE OF INDIANA, S 40
LAKE COUNTY
FILED FOR RECORDS

MAR 4 11 16 AM '69
ANDREW J. MICENKO
RECORDER

CERTIFIED COPY
P. J. Rosenthal
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE DEC. 1. 1968