

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

742694

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No. _____

206

Local No. 848-V

DECEASED—NAME 1. Frank B. Grish		SEX 2. Male	DATE OF DEATH (MONTH DAY YEAR) 3. June 5, 1981
RACE—(e.g. White, Black, American Indian, etc.) 4. White	AGE—Last Birthday (Yrs) 5a. 69yrs.	UNDER 1 YEAR 5b. _____ UNDER 1 DAY 5c. _____	DATE OF BIRTH (Mo. Day Yr.) 6. 5-21-1912
CITY, TOWN OR LOCATION OF DEATH 7b. Dyer, Indiana		HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number) 7c. Our Lady of Mercy Hospital	IF HOSP. OR INST. (Indicate OOA, OP, Emer. Rm., Institution, Specialty) 7d. Inpatient
STATE OF BIRTH (If not in U.S.A. name country) 8. North Carolina	CITIZEN OF WHAT COUNTRY U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10. Married	SURVIVING SPOUSE (If wife, give maiden name) 11. Ethel (Leiby)
SOCIAL SECURITY NUMBER 13. 303-12-8223	USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION. 15a. Indiana	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a. Retired—Grish Brothers	KIND OF BUSINESS OR INDUSTRY 14b. _____
RESIDENCE—STATE 15a. Indiana	COUNTY 15b. Lake	CITY, TOWN OR LOCATION 15c. Dyer, Indiana	IS RESIDENCE ON A FARM? 15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
STREET AND NUMBER 15d. 8513 Parrish Street		INSIDE CITY LIMITS (Specify Yes or No) 15i. Yes	
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g. YES <input type="checkbox"/> NO <input type="checkbox"/>			
FATHER—NAME 16. Michael Grzych		MOTHER—MAIDEN NAME 17. Katherine Rozdal	
INFORMANT—NAME (Type or print) 18a. Ethel Grish		MAILING ADDRESS 18b. 8513 Parrish Street St. John Indiana 46373	
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. Burial		CEMETERY OR CREMATORY—FUNERAL HOME 19b. Oak Hill Cemetery (Hammond)	
DATE (MONTH DAY YEAR) 20a. June 8, 1981		LOCATION 19c. Hammond, Indiana	
To the best of my knowledge, death occurred at the time, date and place and due to the causes stated. 21a. (Signature) <i>John Jones</i>		DATE SIGNED (Mo., Day Yr.) 21b. 6/8/1981	
NAME OF ATTENDING PHYSICIAN (Type or Print) 21d. _____		HOUR OF DEATH 21c. _____	
MAILING ADDRESS—PHYSICIAN 21e. _____		DATE RECEIVED BY LOCAL HEALTH OFFICER 21b. FILED 6-8-81	
HEALTH OFFICER—SIGNATURE 22a. <i>Lee Frey M.D.</i>		DATE RECEIVED BY LOCAL HEALTH OFFICER 21b. FILED 6-8-81	
CONDITIONS IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST			
PART I 23. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))		Interval between onset and death	
(a) Cardiac Arrest DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death	
(b) Severe Coronary Artery Disease DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death	
(c) Chronic Renal Insufficiency		Interval between onset and death	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		AUDITOR LAKE COUNTY 24	

Below for State Office Use
THIS COPY IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JUN 8 1981

FUNERAL HOME
FUNERAL DIRECTOR'S HEALTH COMMISSIONER No. 75-U
LAKE COUNTY HEALTH COMMISSIONER No. _____
LICENSE No. _____
EMBALMER'S NAME: *Lee Frey M.D.*
FUNERAL DIRECTOR'S SIGNATURE: _____

KEY 11-17-20
P W 2 N2 NW NW
S 27 T 35 R 9 3.09 AC
KEY 11-17-33
N 278.40 ft of N 1106.80 ft
SW NW S 27 T 35 R 9 9A

Disposition Permit Issued / /
Provisional Certificate
 Yes No