8CC

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

796839

Local No. 522-84

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No.

Bart R Sikich
3585 Broadway
Merrillville
Suite 510

FILED MAR 25 1985

FUNERAL HOME No. #2

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

1 DECEASED—NAME (First, Middle, Last)	Patricia Ann Sikich
2 SEX	Female
3 DATE OF DEATH (Month Day Year)	March 17, 1984
4 RACE	White
5a AGE—Last Birthday (Yrs)	56
5b UNDER 1 YEAR (Mos, Days)	
5c UNDER 1 DAY (Hours, Mins)	
6 DATE OF BIRTH	November 26, 1927
7a COUNTY OF DEATH	Lake
7b CITY, TOWN OR LOCATION OF DEATH	Merrillville
7c HOSPITAL OR OTHER INSTITUTION	Broadway Southlake
7d IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify)	Inpatient
8 STATE OF BIRTH (If not in U.S.A. name country)	Indiana
9 CITIZEN OF WHAT COUNTRY	USA
10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED	married
11 SURVIVING SPOUSE	Bart
12 WAS DECEDENT EVER IN U.S. ARMED FORCES?	no
13 SOCIAL SECURITY NUMBER	311-26-0163
14a USUAL OCCUPATION	Nurse Coordinator
14b KIND OF BUSINESS OR INDUSTRY	Methodist Hospital

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION

15a RESIDENCE—STATE	Indiana
15b COUNTY	Lake
15c CITY, TOWN OR LOCATION	Merrillville
15d STREET AND NUMBER	6417 Cleveland Street
15e IS RESIDENCE ON A FARM?	YES ☐ NO ☒
15f INSIDE CITY LIMITS (Specify yes or no)	no
15g IS DECEASED OF SPANISH DESCENT? If yes specify Mexican, Cuban, Puerto Rican, etc.	YES ☐ NO ☒

PARENTS

16 FATHER—NAME (First, Middle, Last)	Carl K. Huber
17 MOTHER—MAIDEN NAME (First, Middle, Last)	Nora
18a INFORMANT—NAME (Type or print), RELATIONSHIP	Bart Sikich, Husband
18b MAILING ADDRESS	6417 Cleveland St., Merrillville, Indiana

DISPOSITION

19a BURIAL, CREMATION, REMOVAL, OTHER (Specify)	Burial
19b CEMETERY OR CREMATORY—FUNERAL HOME	Calumet Park Cemetery
19c LOCATION (City or Town, State)	Merrillville, Indiana
20a DATE (Month Day Year)	March 20, 1984
20b FUNERAL HOME (Name and Address)	Stilinovich & Wiatrolik, 7535 Taft, Merrillville, Ind.

M.D. OR D.O.

21a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated (Signature)	[signature]
21b DATE SIGNED (Mo Day Yr)	
21c HOUR OF DEATH	
21d NAME OF ATTENDING PHYSICIAN (Type or Print)	Dr. B. Barai
21e MAILING ADDRESS—PHYSICIAN	521 86th Ave., Merrillville, Indiana 46410
22a HEALTH OFFICER (Signature)	Dean C. Johnson M.D.
22b DATE RECEIVED BY LOCAL HEALTH OFFICER	3-20-84

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

23 PART I

	Immediate cause (Enter only one cause per line for (a), (b) and (c))	Interval between onset and death
(a)	Cardio Respiratory Failure	3 Days
	Due to, or as a consequence of	
(b)	Carcinoma of Ovary with Metastases	6 Mo.
	Due to, or as a consequence of	
(c)		

PART II — Other significant conditions: Conditions contributing to death but not related to cause given in PART I (a)

24 AUTOPSY (Specify Yes or No)

LICENSE No. 419

FUNERAL DIRECTOR'S LICENSE No. 968

EMBALMER'S NAME James Cholston

FUNERAL DIRECTOR'S SIGNATURE

Below for State Office Use

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AUDITOR LAKE COUNTY

MAR 25 3 07 PM '85 RECORDER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

SBH 06-003 State Form 35430
REV. 10/77