TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED NAME — FIRST: Stanislaw — MIDDLE: — LAST: Wasik
2. SEX: Male
3. DATE OF DEATH (Mo. Day Yr): July 6, 1988
4. SOCIAL SECURITY NUMBER: 285-38-5968
5a. AGE—Last Birthday (Years): 80
5b. UNDER 1 YEAR — Months — Days
5c. UNDER 1 DAY — Hours — Minutes
6. DATE OF BIRTH (Month, Day, Year): 6-30-1908
7. BIRTHPLACE (City and State or Foreign Country): Gatezowie, Poland
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: NoNe
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville,
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marianna Mazur
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Coiler
12b. KIND OF BUSINESS/INDUSTRY: Sheet & Tin
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 3733 Vermont
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46409
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Micahel Wasik
18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Abramowicz

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Marianna Wasik
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3733 Vermont, Gary, IN 46409
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 9, 1988 Calvary Cemetery
20c. LOCATION—City or Town, State: Portage, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
21b. LICENSE NUMBER (of Licensee): FDE1001293
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Stilinovich & Wiatrolik-FDH3004455 7535 Taft St., Merrillville, IN

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a. To the best of my knowledge, death occurred at the time, date, and place stated — Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 02:14A M
25. DATE PRONOUNCED DEAD (Month, Day, Year)
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

FILED SEP 1_ 1988

CAUSE OF DEATH — SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. CARCINOMA OF COLON WITH LIVER METASTASES
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Anna M. Anton
AUDITOR, LAKE COUNTY

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: MYELODYSPLASTIC SYNDROME

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

SEP 9 43 AH '88 — FILED FOR RECORD — LILLIAN A. BLASTICK — RECORDER LAKE COUNTY — CROWN POINT, INDIANA — 013307

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

JUL 7 1988

CERTIFIER — SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)
[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
LAKE COUNTY HEALTH COMMISSIONER
29c. LICENSE NUMBER: 30107
29d. DATE SIGNED (Month, Day, Year): 7/7/88
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Dr. Barai, 521 E. 86th Ave., Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul A. Johnson MD
32. DATE FILED (Month, Day, Year): 7/8/88

CORONER OR MEDICAL EXAMINER USE ONLY

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

SBH06-004 State Form 10110 Rev 10.87 — DEATH RD

Key #43-355-12
Great Gary Realty's Co. 1st Add.
L.13 & L.14 BL.11
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