[redacted]

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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1840-88 997561 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST: JOHANNA MIDDLE: L. LAST: JANICZEK
2. SEX: Female
3. DATE OF DEATH (Mo. Day Yr.): September 2, 1988
4. SOCIAL SECURITY NUMBER: 312-42-5810
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): 12-13-1924
7. BIRTHPLACE (City and State or Foreign Country): AUSTRIA
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): JAN JANICZEK
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY: HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 2940 DECATUR STREET
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46405
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ 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): MATTHIAS RUSSEGGER (DEC)
18. MOTHER'S NAME (First, Middle, Maiden Surname): KAROLINE KOFLER (DEC)

INFORMANT

19a. INFORMANT'S NAME (Type/Print): JAN JANICZEK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2940 DECATUR, LAKE STATION, IN 46405
19c. Relationship: SPOUSE

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 6, 1988 CALVARY CEMETERY
20c. LOCATION—City or Town, State: PORTAGE, INDIANA
21a. SIGNATURE OF FUNERAL DIRECTOR: Gerald V. Rees
21b. LICENSE NUMBER (of Licensee): FDE1041083
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME- FDH3003069 600 WEST OLD RIDGE RD., HOBART, IN 46

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: 10:05P M
25. DATE PRONOUNCED DEAD (Month, Day, Year): SEPTEMBER 2, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

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. ADENOCARCINOMA, STOMACH (LINITIS PLASTICA)
DUE TO (OR AS A CONSEQUENCE OF):
b. WITH METASTASIS TO ABDOMEN-PERITONEUM
DUE TO (OR AS A CONSEQUENCE OF):
c. LUNG (EFFUSION); BOWEL OBSTRUCTION
DUE TO (OR AS A CONSEQUENCE OF):
d. PNEUMONIA, SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
☒ 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.

FILED LAKE COUNTY HEALTH DEPARTMENT SEP 15 1988

29b. SIGNATURE AND TITLE OF CERTIFIER: Rodolfo L. Jao
29c. LICENSE NUMBER: 0102611B
29d. DATE SIGNED (Month, Day, Year): 9-6-88
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): RODOLFO L. JAO MD, 1400 SOUTH LAKE PARK AVE, HOBART, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Ruth Johnson MD
Alexa N. Antos AUDITOR LAKE COUNTY
32. DATE FILED (Month, Day, Year): SEP 7, 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)

FILED FOR RECORD 12 07 PM '88 LILLIAN A. BLASTICK RECORDER, LAKE COUNTY CROWN POINT, INDIANA 46307

2ND ADD TO NEW CHICAGO LOT 6, 7, 8, 9 BLK 3 KEY# 21-15-13

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1