

INDIANA STATE BOARD OF HEALTH

THIS CERTIFIES THAT THIS IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE INDIANA STATE HEALTH DEPARTMENT.

Local No. 33-092863

CERTIFICATE OF DEATH

APR 13 1988 Date Issued Franklin D. Remuda M.D. Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

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

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR EXAMINER USE ONLY

1 DECEASED—NAME FIRST LEO MIDDLE R. LAST SIWIRSKI SEX Male DATE OF BIRTH (Mo. Day, Yr) April 12, 1988

2 SOCIAL SECURITY NUMBER 133-10-2543 5a AGE—Last Birthday (Years) 72 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Month Day Year) Oct. 4, 1915 7 BIRTHPLACE (City and State or Foreign Country) Medina, New York

8 YEAR LAST SERVED IN U.S. ARMED FORCES? NO 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) 961 Michigan Ave. 9c CITY, TOWN OR LOCATION OF DEATH Hammond, Indiana 9d COUNTY OF DEATH Lake

10 MARITAL STATUS—Married Never Married Widowed Divorced (Specify) married 11 SURVIVING SPOUSE (If wife, give maiden name) Carol Karas 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Carpenter 12b KIND OF BUSINESS/INDUSTRY (Specify) Woodmar Mall

13a RESIDENCE—STATE Indiana 13b COUNTY Lake 13c CITY, TOWN OR LOCATION Hammond 13d STREET AND NUMBER 961 Michigan Ave.

13e INSIDE CITY LIMITS? (Yes or no) yes 13f FARM no 13g ZIP CODE 46320 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) 10th College (1-4 or 5+) 10th

17 FATHER'S NAME (First, Middle, Last) George Siwirski 18 MOTHER'S NAME (First, Middle, Maiden Surname) Babina Nowinski

19a INFORMANT'S NAME (Type/Print) Carol Karas 19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 961 Michigan Ave., Hammond, Ind. 46320 19c Relationship Wife

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) Sacred Heart Cemetery April 16, 1988 20c LOCATION—City or Town, State Medina, New York

21a SIGNATURE OF FUNERAL DIRECTOR Anthony Solan 21b LICENSE NUMBER (of licenses) FD# 1051840 22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME SOLAN FUNERAL HOME FH# 3002893 7109 Calumet Ave., Hammond, Ind. 46324

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) Apr 13 1988

24 TIME OF DEATH 11:55 a.m. 25 DATE PRONOUNCED DEAD (Month, Day, Year) April 12, 1988 26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) yes ROBERT REORDER APR 13 1988

27 PART I Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF) b. VENTRICULAR ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF) c. ARTERIO-SCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF) d. CONGESTIVE CARDIOMYOPATHY

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

28a AUTOPSY BY (Yes or no) no 28b AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) no

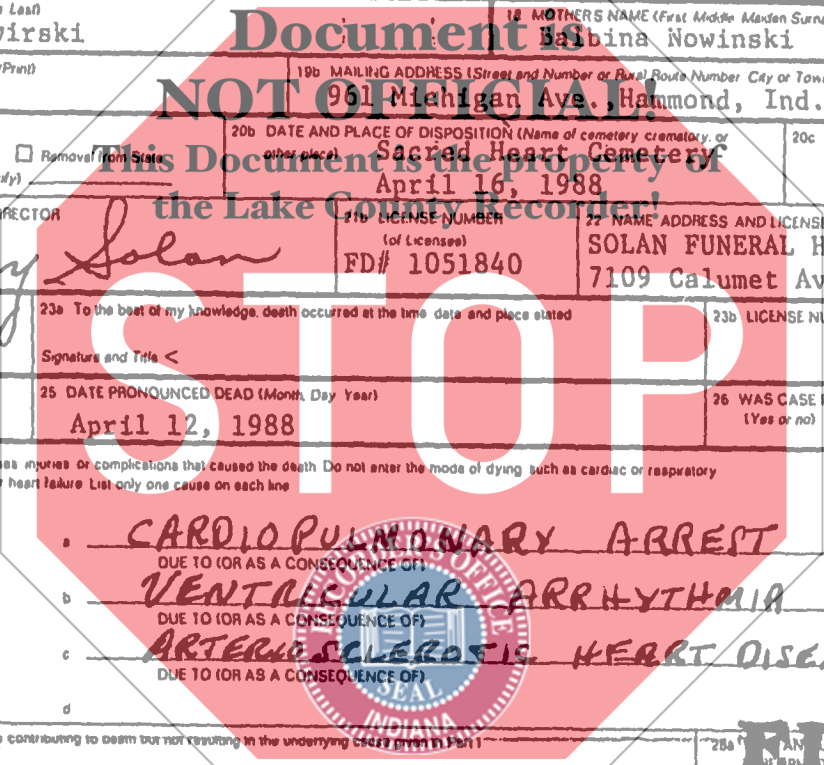
29a CERTIFIER (Check only one)  CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.  PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing 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.

29b SIGNATURE AND TITLE OF CERTIFIER Robert S. Smoltz M.D. 29c LICENSE NUMBER Ind # 01028277 29d DATE SIGNED (Month, Day, Year) 4/13/88 (APRIL 13, 1988)

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type/Print) R.S. Smoltz M.D., 110 Ridge Road, Munster, Indiana 46321

31 HEALTH OFFICER'S SIGNATURE Franklin D. Remuda M.D. 32 DATE FILED (Month, Day, Year) APR 13 1988

33 MANNER OF DEATH  Natural  Pending Investigation  Accident  Suicide  Could not be Determined  Homicide 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)



Key # 26-1384-Stafford with where else above 4.6 E 1/2 L 7

STAT INDIANA S.S. NO. 10594190

APR 13 1988

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