

INDIANA STATE BOARD OF HEALTH

02382

Local No. 6780-88
093816

CERTIFICATE OF DEATH

State No. COMMUNITY TITL. CO. 421 W. H. Avenue
Merrillville, Ind. 46410

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1 DECEASED—NAME FIRST Michael MIDDLE LAST Varso	2 SEX Male		3 DATE OF DEATH (Mo. Day Year) Aug. 24, 1988		
4 SOCIAL SECURITY NUMBER 312-05-3151	5a AGE—Last Birthday 80	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) Mar 3, 1908	7 BIRTHPLACE (City and State or Foreign Country) Pennsylvania
8 YEAR LAST SERVED IN US ARMED FORCES? None	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
9b FACILITY NAME (If not institution give street and number) Methodist Southlake Campus			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) Helen Durica	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life (If not retired) Retired Steelworker		12b KIND OF BUSINESS/INDUSTRY U.S. Steel Co.	
13a RESIDENCE—STATE Ind.	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary		13d STREET AND NUMBER 2074 W. 50th Place	
13e INSIDE CITY LIMITS? (Yes or no) No	13f FARM No	13g ZIP CODE 46408	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban Mexican Puerto Rican etc.) No	15 RACE—American Indian Black White etc. (Specify) White	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5 +) 12
17 FATHER'S NAME (First Middle Last) Michael Varso			18 MOTHER'S NAME (First Middle Maiden Surname) Martha Jarabinec		
19a INFORMANT'S NAME (Type, Print) Helen Varso		19b MAILING ADDRESS (Streeting Number or Rural Route Number City or Town State Zip Code) 2074 W. 50th Place, Gary In 46408		19c Relationship Wife	
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) August 30, 1988 Calumet Park Cemetery		20c LOCATION—City or Town State Merrillville, Ind.		
21a SIGNATURE OF FUNERAL DIRECTOR <i>Cathryn Rendina</i>	21b LICENSE NUMBER INDY 1010402	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home, FDH 30078J 5100 Cleveland St. Gary In 46408			
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)	
24 TIME OF DEATH 6:10p	25 DATE PRONOUNCED DEAD (Month, Day, Year) August 24, 1988		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No		
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. IMMEDIATE CAUSE (If—disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Metabolic pancreatic cancer		Approximate Interval Between Onset and Death		
28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	STATE OF INDIANA LAKE COUNTY FILED APR 5 1 54 PM '88 ROBERT REEDER CLERK			
29a CERTIFIER (Check only one) 1988 <input checked="" type="checkbox"/> 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	29b WAS AN AUTOPSY PERFORMED? (Yes or no)				
29c 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	29d WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)				
30 SIGNATURE AND TITLE OF CERTIFIER <i>P. Terz</i>	31 HEALTH OFFICER'S SIGNATURE <i>Cathryn Rendina</i>		32 DATE SIGNED (Month, Day, Year) 8/29/88	33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> 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)		



FILED

Woods Park Unit #1 Rt 33 #39-502-33

002072 4.00 CM