094257

Local No. 685-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): William Sourounis
2. SEX: Male
3a. TIME OF DEATH: 08:30A M
3b. DATE OF DEATH (Month, Day, Yr.): March 21, 1990
4. SOCIAL SECURITY NUMBER: 313-07-7213
5a. AGE—Last Birthday (Years): 94
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): OCT 5, 1895
7. BIRTHPLACE (City and State or Foreign Country): Diakopto, Greece
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
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 (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 5401 Harrison
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Michael Sourounis
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anastasia N

INFORMANT

20a. INFORMANT'S NAME (Type/Print): James Sourounis
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5401 Harrison, Merrillville, Indiana 46410
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAR 24, 1990 Ridgelawn Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Henry Blake
22b. EMBALMER'S LICENSE NO.: FDE1019406
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b. LICENSE NUMBER (of Licensee): FDE1001293
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH3004455 Stilinovich & Wiatrolik Funeral Home 7535 Taft Street, Merrillville, IN 46410

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms 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. Cardiac Decompensation — Approximate Interval Between Onset and Death: 3/15/90 -

DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial Myopathy — 3/21/90

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I: Diabetes Mellitus; Hypertension

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no):
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
☐ 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) as stated
☐ CORONER 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: M. G. Sala, M.D.
29c. MEDICAL LICENSE NO: 15348
29d. DATE SIGNED (Month, Day, Year): 3/23/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Sala, 5490 Broadway, Merrillville, Indiana

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul Johnson
32. DATE FILED (Month, Day, Year): March 23, 1990

CORONER USE ONLY

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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

000528

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

4.00

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

HEALTH COMMISSIONER

FILED APR 09 1990 Anna M. Anton AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD APR 9 1990 ROBERT ... RECORDER

Key # 15-258-1 Meadowland Estates Unit No. 3 Del. 4.1 - 13C. P