094579

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 637-90 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day, Yr)
Dario Smokvina	Male	8:45A. M	March 16, 1990

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
311-18-3500	74			Sept. 22,1915	Yugoslavia

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
Yes	1946	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Lake County Convalescent Home	Crown Point	Lake

10 MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Ambrosia Hutchison	Millwright	Inland Steel

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	6743 Ohio Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION Elementary/Secondary (0-12)	College (1-4 or 5+)
46323	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	8	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Sylvester Smokvina	Unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Ambrosia Smokvina	6743 Ohio Street, Hammond, In. 46323	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	March 20, 1990 Chapel Lawn Memorial Gardens	Schererville, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Charles D. Scheuer, Jr.	1006049	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John V. Huber (signature) John V. Huber	1045362	Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323 002869

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Gangrene distal one-third left leg with ulcers left
DUE TO (OR AS A CONSEQUENCE OF)
b. Foot secondary to Extensive Venous Thrombosis
DUE TO (OR AS A CONSEQUENCE OF)
c. Of left lower limb with complete obstruction of superficial
DUE TO (OR AS A CONSEQUENCE OF)
d. femoral vein and external iliac vein per venogram 1-11-90

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:
Right CVA (infarct per CT) Head 12-12-89 ... 12-15-89 (2) Diabetes Mellitus
Remarks—Pt and wife refused surgical intervention—wife signed ...

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	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	29c. MEDICAL LICENSE NO	29d DATE SIGNED (Month Day, Year)
(signature) Medical Director	01017249	March 16, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ... Co., 2900 W. 93rd. Avenue, Crown Point, Indiana 46307

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

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
(signature)	March 19, 1990

MAR 19 1990

CORONER USE ONLY

33 MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be Determined				

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? (Specify if driver, passenger, pedestrian, etc)

(signature) HEALTH COMMISSIONER

FILED APR 10 1990 (signature) AUDITOR LAKE COUNTY

000632

4/08

FILED FOR RECORD ROBERT ... RECORDER APR 10 11 08 AM '90 STATE OF INDIANA S.S. NO.

Left margin: 2226 ... Lot 11 Block 7

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