738-3631

Claim # B364878 attn Dolph Seals

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 58 095153

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Chester J. Kucharski
2. SEX	Male
3. DATE OF DEATH (Mo. Day Yr.)	February 10, 1989
4. SOCIAL SECURITY NUMBER	316-24-7594
5a. AGE—Last Birthday (Years)	61
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Month Day Year)	July 19, 1927
7. BIRTHPLACE (City and State or Foreign Country)	East Chicago, IN
8. YEAR LAST SERVED IN US ARMED FORCES?	yes 1946
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. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	East Chicago
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	Never Married
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)	Craneman
12b. KIND OF BUSINESS/INDUSTRY	Railroad
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	East Chicago
13d. STREET AND NUMBER	5505 Reading Avenue
13e. INSIDE CITY LIMITS? (Yes or no)	Yes
13f. FARM	No
13g. ZIP CODE	46312
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
15. RACE—American Indian, Black, White, etc. (Specify)	White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	10

PARENTS

Field	Entry
17. FATHER'S NAME (First, Middle, Last)	John Kucharski
18. MOTHER'S NAME (First, Middle, Maiden Surname)	Katherine Fronczek

INFORMANT

Field	Entry
19a. INFORMANT'S NAME (Type/Print)	Helen Kneeland
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	5505 Reading Ave., East Chicago, IN 46312 Sister

DISPOSITION

Field	Entry
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)	February 14, 1989 Holy Cross Cemetery
20c. LOCATION—City or Town, State	Calumet City, Illinois
21a. SIGNATURE OF FUNERAL DIRECTOR	Keith D. Anthony
21b. LICENSE NUMBER (of Licensee)	01011911
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Anthony & Dziadowicz F.H. 83002835, 4404 Cameron Ave., Hammond, IN 46327

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

Field	Entry
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

Field	Entry
24. TIME OF DEATH	1:31 p M
25. DATE PRONOUNCED DEAD (Month, Day, Year)	February 10, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)	Yes

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.	Ventricular Fibrillation / Asystole	
DUE TO (OR AS A CONSEQUENCE OF): b.	Myocardial Infarction / Pulmonary Edema and Congestion	
DUE TO (OR AS A CONSEQUENCE OF): c.	Coronary Atherosclerosis	
DUE TO (OR AS A CONSEQUENCE OF): d.		

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: Natural / Generalized Arteriosclerosis

Field	Entry
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	Yes

FILED

APR 12 1990

Anne M. Anton
AUDITOR LAKE COUNTY

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	John A Griep, MD
29c. LICENSE NUMBER	01023611
29d. DATE SIGNED (Month, Day, Year)	2/11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)	John A. Griep M.D. St. Catherine Hospital, East Chicago, IN 46312

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	E. A. Campagna, MD
32. DATE FILED (Month, Day, Year)	2-15-89

CORONER OR MEDICAL EXAMINER USE ONLY

Field	Entry
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)	

4.00

Key# 30-596-43 Roxana Park 4th Add 443 N.6 Ft L42 S.1 Ft L44 BL 3

SBH06-004 State Form 110 (R/10-87) DEATH PD 1

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