

09588

Alga Stancik
71615 171st Street, Hammond, IN 46324
INDIANA STATE BOARD OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
Date issued: April 9, 1990
Hammond Health Commissioner

Local No. 315

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

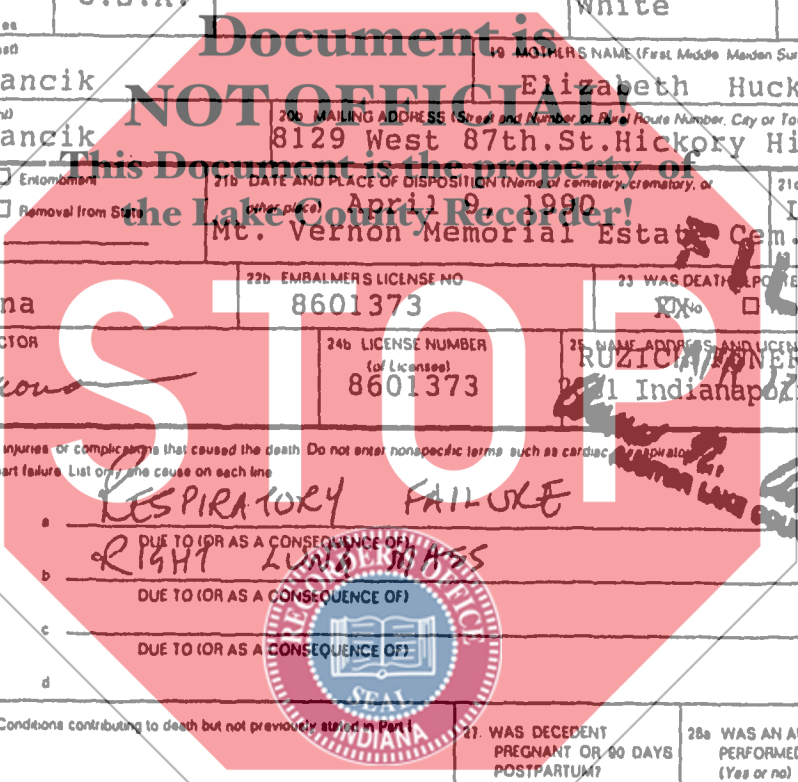
CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1 DECEASED—NAME (First Middle Last) MICHAEL STANCIK | | 2 SEX Male | | 3a TIME OF DEATH 4.15AM | | 3b DATE OF DEATH April 6, 1990 | |
| 4 SOCIAL SECURITY NUMBER 320-03-6923 | | 5a AGE—Last Birthday (Years) 85 | | 5b UNDER 1 YEAR Months Days | | 5c UNDER 1 DAY Hours Minutes | |
| 6a WAS DECEDENT A US VETERAN? Yes | | 6b YEAR LAST SERVED IN US ARMED FORCES? 1946 | | 8 DATE OF BIRTH (Mo. Day, Yr.) June 17, 1904 | | 7 BIRTHPLACE (City and State or Foreign Country) Czechoslovakia | |
| 8a FACILITY NAME (If not institution, give street and number) Hammond-Whiting Convalescent Center | | | | 8c CITY, TOWN, OR LOCATION OF DEATH Hammond | | 8d COUNTY OF DEATH Lake | |
| 10 MARITAL STATUS (Specify) Married | | 11 SURVIVING SPOUSE (If wife give maiden name) Olga Kaczmariski | | 12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Oiler | | 12b KIND OF BUSINESS/INDUSTRY Steel Industry | |
| 13a RESIDENCE—STATE Indiana | | 13b COUNTY Lake | | 13c CITY, TOWN, OR LOCATION Hammond | | 13d STREET AND NUMBER 1615 West 171st Street | |
| 13e ZIP CODE 46624 | | 13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | | 14 CITIZEN OF WHAT COUNTRY? U.S.A. | | 15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) | |
| 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | 16 RACE—American Indian, Black, White, etc. (Specify) White | | 17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary (8) Secondary (10-12) College (1-4 or 5+) 8 | | | |
| 18 FATHER'S NAME (First Middle Last) Michael Stancik | | | | 19 MOTHER'S NAME (First Middle Maiden Surname) Elizabeth Hucko | | | |
| 20a INFORMANT'S NAME (Type/Print) Mr. Steve Stancik | | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8129 West 87th St. Hickory Hills, ILL 60457 | | 20c Relationship Brother | | | |
| 21a 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) | | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 9, 1990 Mt. Vernon Memorial Estate Cem. | | 21c LOCATION—City or Town, State Lemont, Illinois | | | |
| 22a EMBALMER'S NAME Jose G. Corona | | 22b EMBALMER'S LICENSE NO. 8601373 | | 23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>Jose G. Corona</i> | | 24b LICENSE NUMBER (of Licensee) 8601373 | | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME RUZICKA FUNERAL HOME #3020724 221 Indianapolis Blvd. Whiting, Ind. 46394 | | | |
| 26 PART I Enter the diseases, injuries, or complications that caused the death. Do not erect nonspecific terms such as cardiac 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 RESPIRATORY FAILURE APR 17 1990 | | | | | | | |
| b RIGHT LUNG MASS APR 17 1990 | | | | | | | |
| c DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | |
| d DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | |
| PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I | | | | | | | |
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) 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) NO | | | |
| 29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i> | | 29c MEDICAL LICENSE NO. 29302 | | 29d DATE SIGNED (Month, Day, Year) April 9, 1990 | |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Dr. Nitin Sardesai M.D. 921 Fran Lyn, Munster Indiana | | | | | | | |
| 31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> | | | | | | 32 DATE FILED (Month, Day, Year) APR 09 1990 | |
| 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) | |
| 34g DATE PRONOUNCED DEAD (Month, Day, Year) | | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. | | | | 000586 | |

#34-338-17
Homestead Gardens
St 17 W W. 2. 57 deff Bl 3



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