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INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 21 095715

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jan 8, 1990 — Date Issued — Franklin I.O. Premuda M.D., Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Julia M. Krupa
2 SEX: Female
3a TIME OF DEATH: 10:55A M
3b DATE OF DEATH (Month Day Yr): January 7, 1990
4 SOCIAL SECURITY NUMBER: 306-01-9789
5a AGE—Last Birthday (Years): 74
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): MAY 24, 1915
7 BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a WAS DECEDENT A U S VETERAN? No
8b YEAR LAST SERVED IN US ARMED FORCES?
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 6821 California Avenue
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS: 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): Clerk
12b KIND OF BUSINESS/INDUSTRY: Assessors Office
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 6821 California Avenue
13e ZIP CODE: 46323
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc)
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): John Svabik
19 MOTHER'S NAME (First Middle Maiden Surname): Anna Krakornik

INFORMANT

20a INFORMANT'S NAME (Type/Print): Elizabeth Pocci
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10019 4th Street, Highland, IN 46322
20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 10, 1990 St. John Cemetery
21c LOCATION—City or Town, State: Hammond, Indiana
22a EMBALMER'S NAME: Charles D. Scheuer Jr.
22b EMBALMER'S LICENSE NO: 1006049
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: John V. Huber (signature) John V. Huber
24b LICENSE NUMBER (of Licensee): 1045362
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323

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. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Arteriosclerotic heart dis
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

FILED APR 17 1990 — Anna R. Antkus, Lake County Recorder

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: Hypertension
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):

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: John Mason MD
29c MEDICAL LICENSE NO: 17753
29d DATE SIGNED (Month Day Year): Jan. 1-8-90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): John C. Mason M.D., 7905 Calumet Avenue, Hammond Clinic, Hammond, Indiana 46323

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin I.O. Premuda M.D.
32 DATE FILED (Month Day Year): JAN 0 8 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

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4.00 tk

Key # 34-58-9 Hastings Addition 2nd Add. N1/2 Lot 3 Blk 8

STATE OF INDIANA/S.S. NO. LAKE COUNTY FILED FOR RECORD

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

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