PAY SZARMICK 1707 INDI Blud INC 195-8 896364 INDIANA STATE BOARD OF HEALTH Klommond, IN CERTIFICATE OF DEATH 463.27 State No. .. PRINTE DECEASED-NAME 3 DATE OF DEATH (Me Day 11) MIDDLE LAST January 31, 1989 Male Leonard Pastuszak 4 SOCIAL SECURITY NUMBER Se AGE-Last Bethden 7 BIRTHPLACE (Cay and State or Foreign Country) & DATE OF BIRTH (Month Sh UNDER I YEAR SC UNDER I DAY 4-17-1931 Months ... Days Moutes Hours 311-28-0903 57 Hammond, IN YEAR LAST SERVED IN 94 PLACE OF DEATH (Check note one See metrichans) HOSPITAL I Inpatient ER/Outpetient DOA OTHER Nursing Home Residence Other (Specify) 07/13/54 96 FACILITY NAME (If not institution give street and number) SE CITY, TOWN OR LOCATION OF DEATH 94 COUNTY OF DEATH Lake <u>St. Anthony Medical Center</u> Crown Point 10 MARITAL STATUS-Married 12. DECEDENT'S USUAL OCCUPATION 11 SURVIVING SPOUSE 126 KIND OF BUSINESS, INDUSTRY Never Merried Widowed (Give kind of work done during most of working Mr. Do not use repred) heet Metal Worker Dworced (Specify)
Married <u>Gloriann Lukaszewski</u> Local #20 134 RESIDENCE-STATE 13b COUNTY 13c CITY TOWN OR LOCATION 13d STREET AND NUMBER 12026 Lee Street Lake Crown Point 13e INSIDE CITY 13/ FARM 13g ZIP CODE 14 WAS DECEDENT OF HISPANIC ORIGIN? 15 RACE-American Indian 16 DECEDENT'S EDUCATION LIMITS? (Yes or no) (Specify No or Yes - If yes specify Cuben Mexican Puerto Rican etc.) Divide C (Specify only highest grade comple Block White etc tery/Secondary (0-12) NO 46307 Vhite NO 17 FATHERS NAME (First Mickelle Last) PARENT 18 MOTHERS NAME (First Middle Meiden Surner Michael Pastuszak Martha Gonsirowski 196 INFORMANT S NAME (Type/Print) MAILING ADDRESS (Street and Number or Rical Route Number, City or Town, State, Zip Code) INFORMANT Gloriann Pastuszak 12026 Lee Street, Crown Point, IN 46307 Wife METHOD OF DISPOSITION 20c LOCATION—Cey or Town State Other (Specify) ... Crown Point, IN DISPOSITION Mary's Cemetery of 218 SIGNATURE OF SUNERAL DIRECTOR 22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ountsportecordeceisen Funeral Home, Inc.-FD83001253 the Lake (FD01005205 109 N East St, Crown Point, IN46307 PRONOUNCING Complete items 23a-c only when certifying physician is not available at time of death 236 LICENSE NUMBER 23c. DATE SIGNED PHYSICIAN ONLY (Month Day, Year) ITEMS 2 TO HUST 24 TIME OF DEATH 25 DATE PRONOUNCED DEAD (Month, Day Year) 26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER! (Yes or no) No January 31, 1989 4:30A 27 PARTI Enter the diseases, injuries or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory Approximate arrest shock, or heart failure that only one cause on each line Interval Between Onset and Part IMMEDIATE CAUSE (Final Juny cance ... disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) STRUCTIONS **₩** Sequentially list conditions TO SEE HATER DETERMINE BOVE IS A TRUE AND DUE TO COR AS A CONSEQUENCE OF CHURCH CONTROL AND THE CERTIFICATE OF DUE TO COR AS A CONSEQUENCE OF DESCRIPTION OF THE LAKE COUNTY DUE TO (OR AS A CONSEQUENCE OF) 7 5 PART II Other significant conditions contributing to death but not resulting in the underlying cours given in Parti-284. WAS AN AUTOPSY WERE AUTOPSY FINDINGS 28b AVAIDABLE PRIOR TO PERFORMED? OF DEATH? (Yes or not TOU CERTIFIED A CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician countries of the cause(s) and manner as stated LAKE COUNTY HEALTH E PROMOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing deeth and certifying cause of deeth 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 and/or investor on, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated 296 SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d DATE/SIGNED (Month. Day. Year) Tare 01031667 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type/Print) P.J. Tara, M.D., 8127 Merrillville Road, Merrillville, Indiana 46410 31 HEALTH OFFICERS SIGNATURE 32 BATE FILED (Month Des **HEALTH OFFICER** <u>resim</u> DATE OF CURY 33 MANNER OF DEATH 34c. INJURY AT WORK? 344 DESCRIBE HOW INJURY OCCURRED (Month Day, Year) INJURY Pending **CORONER OR** ☐ Natural 001302 MEDICAL Acciden **EXAMINER USE** ☐ Suicide ☐ Could not be 34e PLACE OF INJURY—At home farm, street factory office building etc (Specify) 341 LOCATION (Street and Number or Rural Route Number, City or Town State) ONLY ☐ Homicide SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1