Charles E Daugherty
6 E 67th Ave
Merr. 46410

Local No. 097439 132-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): JULIA F. MANIAK	2 SEX: Female	3a TIME OF DEATH: 6:15 AM	3b DATE OF DEATH (Month Day Yr): April 2, 1990
4 SOCIAL SECURITY NUMBER: 317-09-9246	5a AGE—Last Birthday (Years): 70	5b UNDER 1 YEAR (Months / Days) — 5c UNDER 1 DAY (Hours / Minutes)	6 DATE OF BIRTH (Mo Day Yr): February 16, 1920
7 BIRTHPLACE (City and State or Foreign Country): Butler, Pennsylvania			
8a WAS DECEDENT A U.S. VETERAN?: No	8b YEAR LAST SERVED IN U.S. ARMED FORCES?:	9a PLACE OF DEATH: HOSPITAL ☒ Inpatient ☐ ER Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)	
9b FACILITY NAME: St. Mary's Medical Center	9c CITY, TOWN OR LOCATION OF DEATH: Hobart	9d COUNTY OF DEATH: Lake	
10 MARITAL STATUS: Married	11 SURVIVING SPOUSE: Joseph Maniak	12a DECEDENT'S USUAL OCCUPATION: Teller	12b KIND OF BUSINESS/INDUSTRY: Gainer Bank
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Merrillville	13d STREET AND NUMBER: 704 West 67th Lane
13e ZIP CODE: 46410	13f INSIDE CITY LIMITS: ☐ No ☒ Yes; 13g ON A FARM?: ☒ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY?: U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes
16 RACE: White	17 DECEDENT'S EDUCATION: Elementary/Secondary (0-12): 12; College (1-4 or 5+):		

PARENTS

18 FATHER'S NAME: Anthony Fusiek	19 MOTHER'S NAME (First Middle Maiden Surname): Aniela Kula

INFORMANT

20a INFORMANT'S NAME: Joseph Maniak	20b MAILING ADDRESS: 704 W. 67th Ln., Merrillville, IN 46410	20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State	21b DATE AND PLACE OF DISPOSITION: April 5, 1990 Calvary Cemetery	21c LOCATION—City or Town, State: Portage, Indiana
22a EMBALMER'S NAME: Charles Wells	22b EMBALMER'S LICENSE NO: 1042372	23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b LICENSE NUMBER (of Licensee): 1007231	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Carcinoma Breast with Widespread Metastasis — Approximate Interval Between Onset and Death: 4 yrs

DUE TO (OR AS A CONSEQUENCE OF)

DUE TO (OR AS A CONSEQUENCE OF)

DUE TO (OR AS A CONSEQUENCE OF)

Conditions if any which gave rise to the immediate cause stating the underlying cause last

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

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

APR 3 1990

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) | 28a WAS AN AUTOPSY PERFORMED? (Yes or no): Yes | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED APR 25 1990 Anna M. Antalis, Lake County Recorder

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.

LAKE COUNTY HEALTH COMMISSIONER

29b SIGNATURE AND TITLE OF CERTIFIER: K. P. Sarma, MD	29c MEDICAL LICENSE NO: 01027669	29d DATE SIGNED (Month Day Year): 4/3/90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): K.P. SARMA, M.D. 300 WEST 61ST AVENUE HOBART, IN 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] | 32 DATE FILED (Month Day Year): April 3, 1990

CORONER USE ONLY

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)			
34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			

001198

#15-334 70 Turkey Ck. Mead #2 Lt 140 E 38-100 th' Lt 13

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