8cc plus vet GASTEVICH PETE SUFANA

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 868.90 098082 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	WILLIAM J O'BRIEN
2. SEX	MALE
3a. TIME OF DEATH	2:45 A.M.
3b. DATE OF DEATH (Month, Day, Yr)	APRIL 14, 1990
4. SOCIAL SECURITY NUMBER	110-36-1587
5a. AGE—Last Birthday (Years)	44
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	FEBRUARY 9, 1946
7. BIRTHPLACE (City and State or Foreign Country)	NEW YORK, NEW YORK
8a. WAS DECEDENT A U.S. VETERAN?	YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	MARCH 1974
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST. ANTHONY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH	CROWN POINT
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	DONNA L KULESA
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	SPECIAL AGENT
12b. KIND OF BUSINESS/INDUSTRY	FEDERAL BUREAU OF INVESTIGATION
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	CROWN POINT
13d. STREET AND NUMBER	965 PAWNEE DRIVE
13e. ZIP CODE	46307
13f. INSIDE CITY LIMITS	☐ No [X] Yes
13g. ON A FARM?	[X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	College: 4

PARENTS

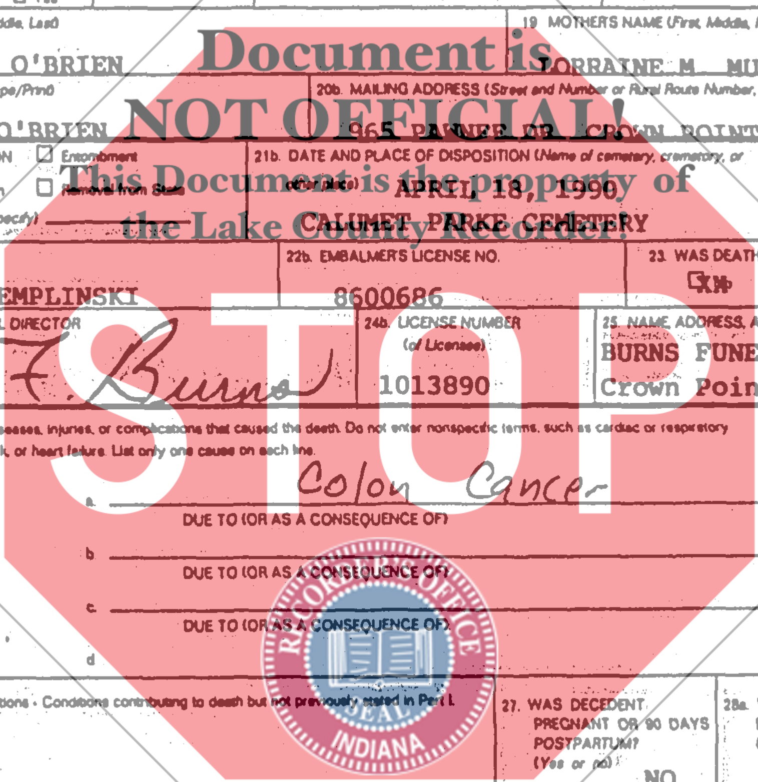
Field	Entry
18. FATHER'S NAME (First, Middle, Last)	WILLIAM J. O'BRIEN
19. MOTHER'S NAME (First, Middle, Maiden Surname)	LORRAINE M. MURPHY

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	DONNA L. O'BRIEN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	965 PAWNEE DR. CROWN POINT, IN 46307
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	APRIL 18, 1990 CALUMET PARKE CEMETERY
21c. LOCATION—City or Town, State	MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME	DAVID W. SEMPLINSKI
22b. EMBALMER'S LICENSE NO.	8600686
23. WAS DEATH REPORTED TO CORONER?	[X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James F. Burns
24b. LICENSE NUMBER (of Licensee)	1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BURNS FUNERAL HOME, 10101 Broadway Crown Point, IN 46307 FDH8600018



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. Colon Cancer
DUE TO (OR AS A CONSEQUENCE OF)
b.
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

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

Field	Entry
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

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	R. Drasga
29c. MEDICAL LICENSE NO.	01031484
29d. DATE SIGNED (Month, Day, Year)	April 19, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DR. RAY DRASGA 8127 Merrillville Road, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE — [signature]
32. DATE FILED (Month, Day, Year) — APR 20 1990

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

CORONER USE ONLY

Field	Entry
33. MANNER OF DEATH	[X] 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.	

FILED

MAY 01 1990

Anna N. Anton
AUDITOR LAKE COUNTY

LAKE COUNTY HEALTH COMMISSION

Briarwood Unit #8, Lot 204 Unit 23 Key #9-412-14

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

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