1020 W. 7TH Pl HoBRT. 46342

12 Reg
2 Ver
14 Total

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 4580 90 099554 099554

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First, Middle, Last)	BERNARD W. MAKOWIECKI
2. SEX	MALE
3a. TIME OF DEATH	2:30P M
3b. DATE OF DEATH (Month, Day, Yr)	MAY 3, 1990
4. SOCIAL SECURITY NUMBER	311-46-4482
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)	DECEMBER 24, 1945
7. BIRTHPLACE (City and State or Foreign Country)	BADENWEILER, WEST GERMANY
8a. WAS DECEDENT A U.S. VETERAN?	YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1968
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient XX ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH	HOBART
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	DIVORCED
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)	ENGINEER
12b. KIND OF BUSINESS/INDUSTRY	EJ & E RAILROAD
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HOBART
13d. STREET AND NUMBER	1020 WEST 7TH PLACE
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	☐ No XX Yes
13g. ON A FARM?	XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX 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+)	12

PARENTS

Field	Value
18. FATHER'S NAME (First, Middle, Last)	THOMAS MAKOWIECKI
19. MOTHER'S NAME (First, Middle, Maiden Surname)	GRETCHEN LANGIN

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	RUDY MAKOWIECKI
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2555 NORTH RIDGE DRIVE VALPARAISO, IN 46383
20c. Relationship	BROTHER

DISPOSITION

Field	Value
21a. METHOD OF DISPOSITION	☐ Burial XX Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	MAY 5, 1990 CALVARY CREMATORY
21c. LOCATION—City or Town, State	PORTAGE, INDIANA
22a. EMBALMER'S NAME	JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.	FD01004194
23. WAS DEATH REPORTED TO CORONER?	☐ No XX Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	REES FUNERAL HOMES, INC. FDH3003069 600 W. OLD RIDGE RD, HOBART, IN 46342

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)

a. SEVERE TRIPLE ATHEROSCLEROSIS WITH — Approximate Interval Between Onset and Death: Unknown

DUE TO (OR AS A CONSEQUENCE OF):

b. OCCLUSION OF LEFT MAIN AND LEFT ANTERIOR

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

DUE TO (OR AS A CONSEQUENCE OF):

c. DESCENDING ARTERY. EMPHYSEMATOUS CHANGES

DUE TO (OR AS A CONSEQUENCE OF):

d. OF LUNGS WITH CONGESTION.

PART II. Other significant conditions. Conditions contributing to death but not resulting in the underlying cause given in Part I.

Field	Value
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	YES
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	YES

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.

XX 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: Daniel Thomas, M.D.

Field	Value
29c. MEDICAL LICENSE NO.	16120
29d. DATE SIGNED (Month, Day, Year)	MAY 7, 1990

29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DANIEL THOMAS, MD, 2293 NORTH MAIN STREET, CROWN POINT, IN 46307

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

LAKE COUNTY HEALTH COMMISSIONER

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE

FILED

32. DATE FILED (Month, Day, Year): May 7 1990

CORONER USE ONLY

Field	Value
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)	MAY 3, 1990
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

MAY 9 1990

Anna N. Anton
AUDITOR LAKE COUNTY

006637

RECORDED ... MAY ... 1990 ... RECORD NO.

Reg # 18-32-17 Hobart Ridgewood Add. S 500 ft ... E 31.25 ft ... 07-13-13??

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

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