152352
4001-89

Local No. 089621

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TICOR TITLE INSURANCE Crown Point, Indiana Merrillville ①

State No.

Unit 8 Key No. 15-405-25

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	L. ROSE RACICH
2 SEX	FEMALE
3a TIME OF DEATH	1;43P M
3b DATE OF DEATH (Month Day Yr)	August 15, 1989
4 SOCIAL SECURITY NUMBER	317-09-2840
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)	October 12, 1918
7 BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
8a WAS DECEDENT A U.S. VETERAN?	N/A
8b YEAR LAST SERVED IN U.S. 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)	Methodist Hospital Southlake
9c CITY, TOWN OR LOCATION OF DEATH	Merrillville
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Widowed
11 SURVIVING SPOUSE (If wife give maiden name)	N/A
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Homemaker
12b KIND OF BUSINESS/INDUSTRY	Self
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	Merrillville
13d STREET AND NUMBER	893 W. 72nd Drive
13e ZIP CODE	46410
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): 12; College (1-4 or 5+):

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Frank Yurisich
19 MOTHER'S NAME (First Middle Maiden Surname)	Lucielle Bogun

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Joseph Racich
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	5156 Imperial Dr. Richton Park, ILL 60471
20c Relationship	Son

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	August 19, 1989 Calumet Park Cemetery
21c LOCATION—City or Town, State	Merrillville, Indiana
22a EMBALMER'S NAME	Henry Blake
22b EMBALMER'S LICENSE NO.	FDE1019406
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Robert Wiatrolik
24b LICENSE NUMBER (of Licensee)	FDE1001293
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Stilinovich & Wiatrolik FH3004455 7535 Taft St. 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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Myocardial Infarction	1 hr
DUE TO (OR AS A CONSEQUENCE OF) b	Coronary arteriosclerosis	years
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)	
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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	A. Fadul
29c MEDICAL LICENSE NO.	16574
29d DATE SIGNED (Month Day Year)	8-18-89
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Fadul, 8695 Connecticut, Merrillville

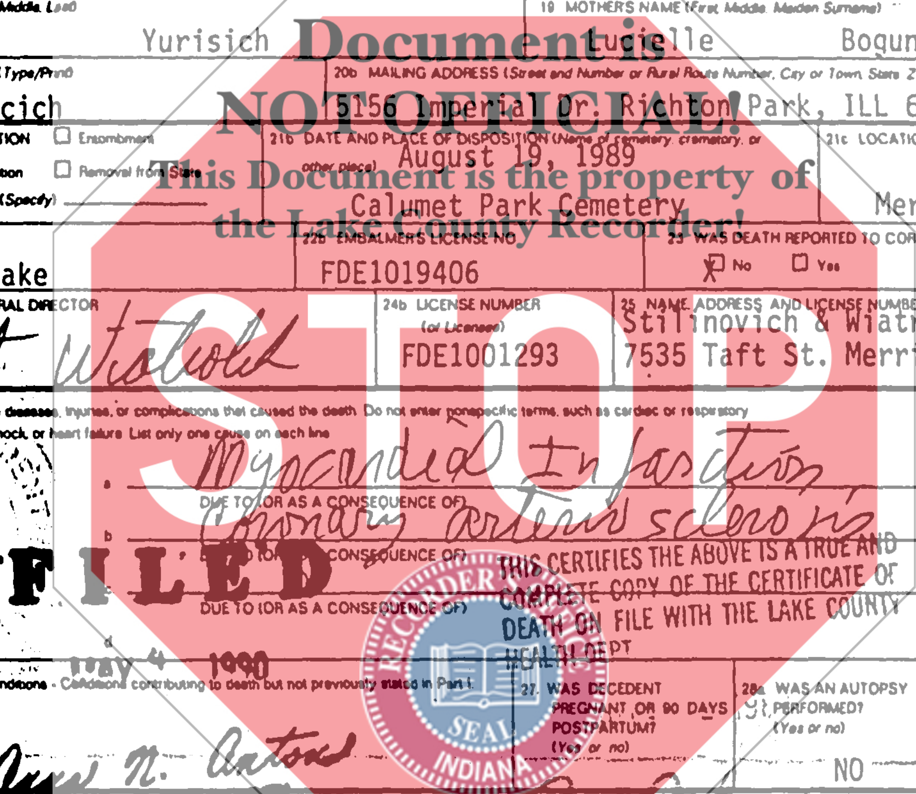
HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Paul A. Johnson MD
32 DATE FILED (Month, Day, Year)	Aug 22, 1989

CORONER USE ONLY

Field	Entry
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.	

4.00 T1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STOP

FILED MAY 4 1990

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

Anna M. Anton, LAKE COUNTY HEALTH COMMISSIONER

RECORDER SEAL INDIANA

STATE OF INDIANA S.S. FILED

Turkey Creek South #3 Lt 134 #15-405-25

Lot 134, Turkey Creek South Unit 3, Plat Book 37 Pg. 74

TICOR TITLE INSURANCE Crown Point, Indiana Merrillville

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

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