GERALD P. KRAY, 9228 [redacted] Hgld 46322

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jan 25, 1990 — Date Issued
Franklin D. [signature] M.D. — Hammond Health Commissioner

Local No. 75

099824

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Stanley Flis
2 SEX	Male
3a TIME OF DEATH	1:04 AM
3b DATE OF DEATH (Month Day Yr)	January 23, 1990
4 SOCIAL SECURITY NUMBER	311-18-3727
5a AGE—Last Birthday (Years)	68
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	May 15, 1921
7 BIRTHPLACE (City and State or Foreign Country)	Hamtramck, MI
8a WAS DECEDENT A US VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1946
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. Margaret Hospital
9c CITY, TOWN OR LOCATION OF DEATH	Hammond
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Stella Lelek
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Welder
12b KIND OF BUSINESS/INDUSTRY	Steel
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	4032 Hohman Avenue
13e ZIP CODE	46327
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+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Anthony Flis
19 MOTHER'S NAME (First Middle Maiden Surname)	Rose Oleksy

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Stella Flis
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4032 Hohman Ave, Hammond, IN 46327
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial; [ ] Cremation; [ ] Donation; [ ] Entombment; [ ] Removal from State; [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	January 26, 1990 Holy Cross Cemetery
21c LOCATION—City or Town, State	Calumet City, IL
22a EMBALMER'S NAME	Keith D. Anthony
22b EMBALMER'S LICENSE NO	01011911
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Keith D. Anthony
24b LICENSE NUMBER (of Licensee)	01011911
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Anthony & Dziadowicz F.H. 83002835 4404 Cameron Avenue, Hammond, IN 46327

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	minutes
DUE TO (OR AS A CONSEQUENCE OF) b	Coronary Artery disease	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

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)

FILED MAY 10 1990

[signature] AUDITOR LAKE COUNTY

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	Alan Jones DO
29c MEDICAL LICENSE NO	640
29d DATE SIGNED (Month Day, Year)	Jan. 24, 1990
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Alan Jones, D.O., 9128 Columbia Avenue, Munster, Indiana 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Franklin D. [signature] M.D.
32 DATE FILED (Month Day, Year)	JAN 25 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.

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4.00

Key# 3-162-15 #07225: Pond Co Wildwood Shores; Key# 35-143-19 N35Ft Lot 14 Blk 27 Wildwood Shores 3rd Add

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