ESTHER GASPAROVIC
1701 S. LAKE PARK AVE.
Hobart 942-9634(?)

INDIANA STATE BOARD OF HEALTH

Local No. 1040-90 **101225** CERTIFICATE OF DEATH State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEDENT—NAME (First Middle Last)	Nicholas M. Gasparovic
2 SEX	Male
3a TIME OF DEATH	1:00 A.M.
3b DATE OF DEATH (Month Day Yr)	May 14, 1990
4 SOCIAL SECURITY NUMBER	312-09-5027A
5a AGE—Last Birthday (Years)	79
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	Nov.12,1910
7 BIRTHPLACE (City and State or Foreign Country)	Hammond, Indiana
8a WAS DECEDENT A U.S. VETERAN?	No
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)	1701 So. Lake Park Ave., Hobart, Ind.46342
9c CITY, TOWN OR LOCATION OF DEATH	Hobart,Indiana
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Esther (Amar)
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Self-Employed
12b KIND OF BUSINESS/INDUSTRY	Liquor Store
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hobart
13d STREET AND NUMBER	1701 So.Lake Park Avenue
13e ZIP CODE	46342
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12 yrs
College (1-4 or 5+)	

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Joseph Gasparovic
19 MOTHER'S NAME (First Middle Maiden Surname)	Pauline Pushtina

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Nicholas Gasparovic
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3557 Oakcrest Place, Crown Point,Ind.46307
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)	May 17, 1990 St. John Cemetery
21c LOCATION—City or Town, State	Hammond, Indiana
22a EMBALMER'S NAME	Charles W. Wells
22b EMBALMER'S LICENSE NO.	1042372
23 WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Anthony Solan (signature)
24b LICENSE NUMBER (of Licensee)	FDO#1051840
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	SOLAN FUNERAL HOME #3002893 7109 Calumet Ave.,Hammond,Indiana 46324

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.	Cardio-pulmonary arrest	Immed
DUE TO (OR AS A CONSEQUENCE OF) b.	Extrinsic Pneumomatosis(?)	
DUE TO (OR AS A CONSEQUENCE OF) c.	Eczema(?)	2 years
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)	

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

FILED MAY 31 1990

SEAL INDIANA

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.

(Signature) LAKE COUNTY

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	John J. Reed M.D. (signature)
29c MEDICAL LICENSE NO.	15866
29d DATE SIGNED (Month Day Year)	5-15-90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	John J. Reed, M.D., 10 Michigan, Hobart, Indiana 46342 942-1131

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	(signature)
32 DATE FILED (Month Day Year)	MAY 15, 90

CORONER USE ONLY

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

#17-184-9 4 10 Lk Co. 1st 9 4 10 Gracken

1245 400

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