Bob Van Til
535 Logan Av Hwy 46320

Local No. 1 377

104165

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

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

MAY 1, 1990 — Franklin [illegible] M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT—NAME (First, Middle, Last): John Thorsky
2. SEX: Male
3a. TIME OF DEATH: 5:55 p.m.
3b. DATE OF DEATH (Month, Day, Yr.): April 27, 1990
4. SOCIAL SECURITY NUMBER: 337-16-6952
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): June 25, 1918
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
9a. PLACE OF DEATH (Check only one. See Instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
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): Noreen Smith
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: Tavern
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 5111 Sohl #330B
13e. ZIP CODE: 46320
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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+): 0

PARENTS

18. FATHER'S NAME (First, Middle, Last): Raymond Thorsky
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Popiel

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Noreen Thorsky
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 State Line Rd., Calumet City, IL 60409
20c. Relationship: Wife

DISPOSITION

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): May 1, 1990 Mount Hope Cemetery
21c. LOCATION—City or Town, State: Chicago, IL
22a. EMBALMER'S NAME: William D. Smith
22b. EMBALMER'S LICENSE NO.: IL 029-011455
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan
24b. LICENSE NUMBER (of Licensee): 1051840
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Solan F.H., Hammond, IN for Nowak F.H. 400 Pulaski Rd., Calumet City, IL 6040

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. Acute and Chronic Heart Failure (acute and chronic heart failure)

DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary artery Disease (coronary artery disease)

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.

FILED
JUN 20 1990
Anna M. Anton
AUDITOR LAKE COUNTY

PART II. Other significant 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):

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Greenwald MD
29c. MEDICAL LICENSE NO.: 20603
29d. DATE SIGNED (Month, Day, Year): May 1, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Greenwald, M.D. 5454 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin [illegible] M.D.
32. DATE FILED (Month, Day, Year): MAY 01 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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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1