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Local No. 736

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.

Sept 6, 1990 — [signature] M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	John S. Molenda
2 SEX	Male
3a TIME OF DEATH	5:35 a. M.
3b DATE OF DEATH (Month Day, Yr)	September 4, 1990
4 SOCIAL SECURITY NUMBER	314-09-7020
5a AGE—Last Birthday (Years)	77
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo. Day, Yr)	June 12, 1913
7 BIRTHPLACE (City and State or Foreign Country)	Chicago, Illinois
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)	Lottie Gonsiorowski
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Technician
12b KIND OF BUSINESS/INDUSTRY	Utility Company
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	4427 Henry 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)	Joseph Molenda
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Rose Ronczy

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Lottie Molenda
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4427 Henry Avenue, 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)	September 6, 1990 Holy Cross Cemetery
21c LOCATION—City or Town, State	Calumet City, Illinois
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 & Dzidowicz FH 83002835 4404 Cameron, 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.	Pneumonia ē abscess formation	
DUE TO (OR AS A CONSEQUENCE OF) b.	Transient ischemic attack	
DUE TO (OR AS A CONSEQUENCE OF) c.	Nephrosclerosis ē End Stage Renal Disease	
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)	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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	J. Greenwald M.D.
29c MEDICAL LICENSE NO	20603
29d DATE SIGNED (Month, Day, Year)	September 4, 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

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature] M.D.
32 DATE FILED (Month, Day, Year)	SEP 06 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.

34i SIGNATURE: Anna N. Antone

FILED
NOV 30 1990

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6.00

SBH06-004 (R11/3-89)

DEA CERT/PD I: D. R. O'Dell 707 E Commercial Ave Lowell 46356

STATE OF INDIANA ... DEC 19 ... 1990

Reg # 3323-12 Rolling Meadows Bk 2 Lot 13

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