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Local No. 710

31,-441

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

Aug. 28, 1990 — Date Issued

Franklin I. Ojemuda M.D. — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

156327

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ANN K. DWAN
2. SEX: Female
3a. TIME OF DEATH: 6:30 AM
3b. DATE OF DEATH (Month, Day, Yr): August 26, 1990
4. SOCIAL SECURITY NUMBER: 308-14-4333
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): October 22, 1918
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
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): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): widowed
11. SURVIVING SPOUSE (If wife, give maiden name): none
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: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7550 Jarnecke Ave.
13e. ZIP CODE: 46324
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): 9th; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Vasil Sichak
19. MOTHER'S NAME (First, Middle, Maiden Surname): Katarina Kwik

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Kathleen Kick
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2729 Sycamore Dr., Dyer, Indiana 46311
20c. (Relationship): Daughter

DISPOSITION

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 28, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: none
22b. EMBALMER'S LICENSE NO.: –
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John S. Bezy
24b. LICENSE NUMBER (of Licensee): FD# 1007231
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH# 3002893, 7109 Calumet Ave., Hammond, Ind. 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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Pneumonia Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):
b. Emphysema Emphysema

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 cited in Part I.
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):

FILED DEC 10 1990 — Oscar N. Anton, Auditor, Lake County

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.
29b. SIGNATURE AND TITLE OF CERTIFIER: John W. George
29c. MEDICAL LICENSE NO.: 0103470
29d. DATE SIGNED (Month, Day, Year): August 28, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): John W. George M.D. 7905 Calumet Ave., Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin I. Ojemuda M.D.
32. DATE FILED (Month, Day, Year): AUG 28 1990

CORONER USE ONLY

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.

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

TICOR TITLE INSURANCE, Crown Point, Indiana

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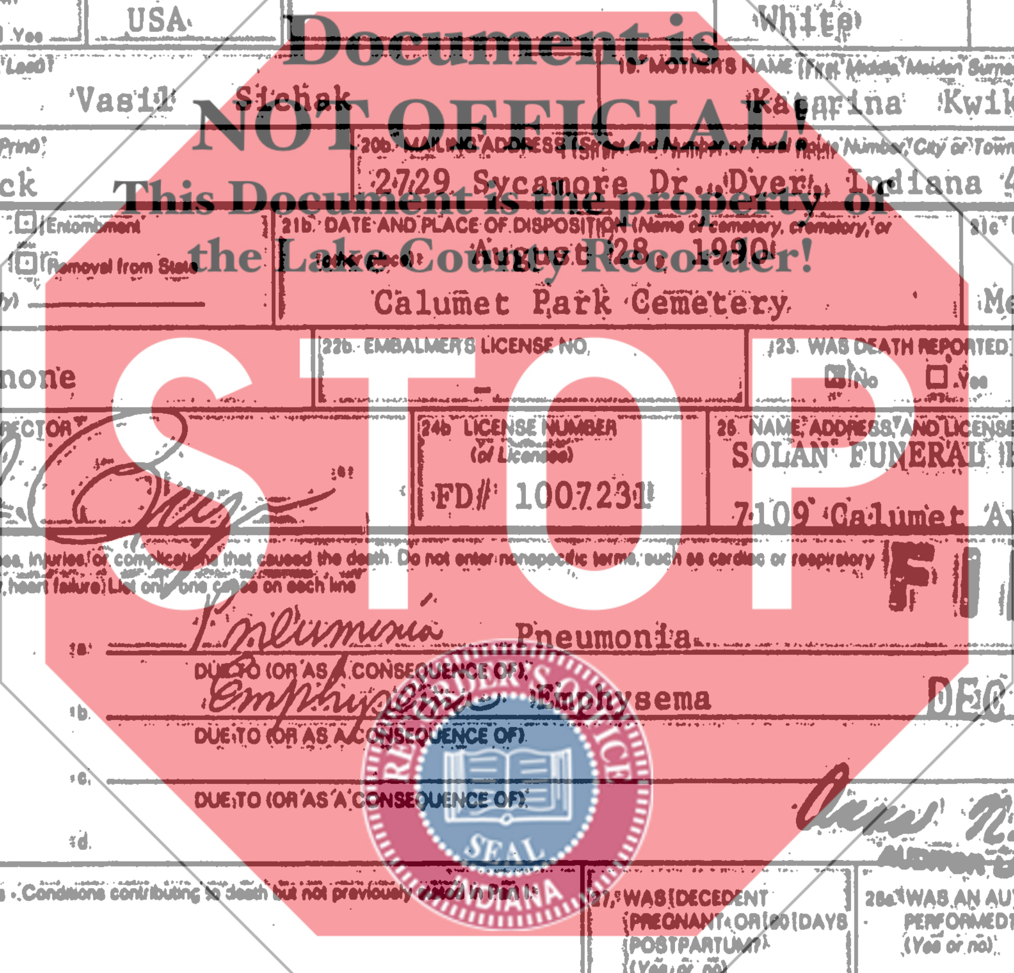
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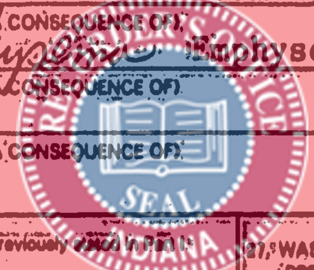
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