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2nd Highland Park Add  
h. 24 + S. 12 1/2 St L. 25,  
both Bl. 7  
State No. ... Key #145-44-24.....  
unit #25

91-0124

# INDIANA STATE BOARD OF HEALTH CERTIFICATE OF DEATH

Local No. .... 91008349

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

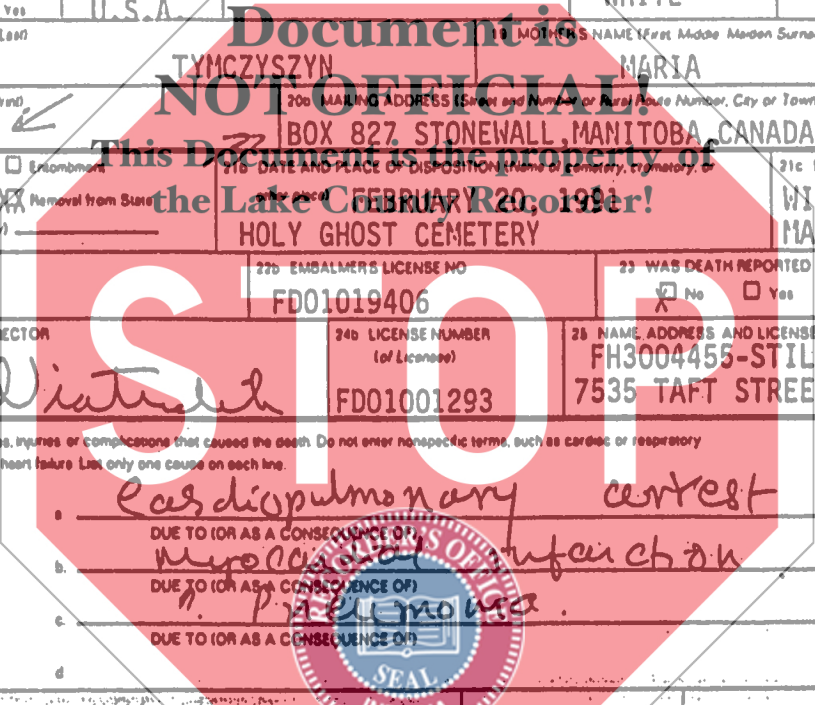
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) <b>MARIA PALCAT</b>		2 SEX <b>FEMALE</b>	3a TIME OF DEATH <b>9:35 P</b>	3b DATE OF DEATH (Month, Day, Yr) <b>FEBRUARY 12, 1991</b>	
4 SOCIAL SECURITY NUMBER <b>312-72-7276</b>	5a AGE—Last Birthday (Years) <b>79</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>JUNE 12, 1911</b>	
7a WAS DECEDENT A US VETERAN? <b>NO</b>	7b YEAR LAST SERVED IN US ARMED FORCES? <b>NONE</b>	7c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8a FACILITY NAME (If not institution, give street and number) <b>ST. MARY'S MEDICAL CENTER-GARY</b>		8b CITY, TOWN OR LOCATION OF DEATH <b>GARY</b>	8c COUNTY OF DEATH <b>LAKE</b>		
10 MARITAL STATUS (Specify) <b>WIDOWED</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>-</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOMEMAKER</b>	12b KIND OF BUSINESS/INDUSTRY <b>SELF</b>		
13a RESIDENCE—STATE <b>INDIANA</b>	13b COUNTY <b>LAKE</b>	13c CITY, TOWN OR LOCATION <b>GARY</b>	13d STREET AND NUMBER <b>3777 VIRGINIA STREET</b>		
13e ZIP CODE <b>46409</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>WHITE</b>	
17a DECEDENT'S EDUCATION (Specify) (Specify) (Specify) (Specify) (Specify) Elementary/Secondary (10-12) <b>2</b> College (1-4 or 5+) <b>2</b>		18 FATHER'S NAME (First Middle Last) <b>JOHN TYMCZYSZYN</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>MARIA</b>		20a INFORMANT'S NAME (Type/Print) <b>FRANK PALCAT</b>			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>BOX 827, STONEWALL, MANITOBA, CANADA R0L 1R2C2</b>		20c Relationship <b>SON</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place) <b>FEBRUARY 20, 1991 HOLY GHOST CEMETERY</b>		21c LOCATION—City or Town, State <b>WINNIPEG, MANITOBA, CANADA</b>	
22a EMBALMER'S NAME <b>HENRY BLAKE</b>		22b EMBALMER'S LICENSE NO. <b>FD01019406</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert Wiatrol</i>		24b LICENSE NUMBER (of Licensee) <b>FD01001293</b>	24c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FH3004455-STILINOVICH &amp; WIATROL II 7535 TAFT STREET, MERRILLVILLE, IN 46410</b>		
26 PART I Enter the disease, 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. IMMEDIATE CAUSE (Final: disease or condition resulting in death) <b>a. Cardio-pulmonary arrest</b> <b>b. Myocardial infarction</b> <b>c. pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>Seizure disorder</b>					
27a WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM (Yes or no) <b>NO</b>					
28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>					
28b WERE AUTOPSY RESULTS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>-</b>					
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>A. Mendelsohn</i>			
29c MEDICAL LICENSE NO. <b>01032180</b>		29d DATE SIGNED (Month, Day, Year) <b>2/14/91</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DR. S. SHAH, 3520 FAIRVIEW AVE, LAKE STATION, IN 46405</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Robert Wiatrol</i>				32 DATE FILED (Month, Day, Year) <b>FEB. 15 1991</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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 (Name and Number or Rural Route Number, City or Town, State)			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) <b>NO</b>			



STATE OF INDIANA, S. No. 08  
LAKE COUNTY, IN  
FEB 22 9 01 AM  
ROBERT W. WIATROL  
RECORDER

**FILED**

**FEB 24 1991**

*Robert Wiatrol*  
AUDITOR LAKE COUNTY

01562