91015076

Local No. 0683-91

Rees Funeral Home 600 W Ridge Rd Hobart 46342 10 Reg 2 Vet 12 Total

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): JOSEPH F. GORSKI	2 SEX: MALE	3a TIME OF DEATH: 9:45 A M	3b DATE OF DEATH (Month Day Yr): MARCH 27, 1991
4 SOCIAL SECURITY NUMBER: 315-12-6486	5a AGE—Last Birthday (Years): 67	5b UNDER 1 YEAR Months Days; 5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr): FEBRUARY 5,1924
7 BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA	8a WAS DECEDENT A US VETERAN? YES	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER	9c CITY, TOWN, OR LOCATION OF DEATH: HOBART	9d COUNTY OF DEATH: LAKE COUNTY	
10 MARITAL STATUS (Specify): MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name): LILLIAN G. MASSACK	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): TOOL & DIE MAKER	12b KIND OF BUSINESS/INDUSTRY: ANDERSON CO./ANCO
13a RESIDENCE—STATE: INDIANA	13b COUNTY: LAKE	13c CITY, TOWN, OR LOCATION: HOBART	13d STREET AND NUMBER: 3801 GILL STREET
13e ZIP CODE: 46342	13f INSIDE CITY LIMITS ☐ No XX Yes; 13g ON A FARM? XX No ☐ Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 11	College (1-4 or 5+):	

PARENTS

18 FATHER'S NAME (First, Middle, Last): JOHN ALEX GORSKI	19 MOTHER'S NAME (First, Middle, Maiden Surname): GENEVIEVE FRANK

INFORMANT

20a INFORMANT'S NAME (Type/Print): LILLIAN G. GORSKI	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 GILL ST, HOBART, IN 46342	20c Relationship: SPOUSE

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): MARCH 29, 1991 EVERGREEN MEMORIAL PARK	21c LOCATION—City or Town, State: HOBART, INDIANA
22a EMBALMER'S NAME: JAMES W. GHOLSTON	22b EMBALMER'S LICENSE NO: FD01004194	23 WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James J. Krause	24b LICENSE NUMBER (of Licensee): FD01006463	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOMES, INC. FH83003069 600 W. RIDGE RD, HOBART, IN 46342

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. Metastatic lung cancer — 6 months

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
b. DUE TO (OR AS A CONSEQUENCE OF)
c. DUE TO (OR AS A CONSEQUENCE OF)
d.

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): N/A	28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

Stamps: FILED MAR 28 1991 ... LAKE COUNTY HEALTH COMMISSIONER — Alexander S. Williams, M.D.; FILED FOR RECORD APR 23 1991 ... Anna N. Anton RECORDER LAKE COUNTY

#17174-45

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: Mary Y Klein MD	29c MEDICAL LICENSE NO: 01034294	29d DATE SIGNED (Month, Day, Year): March 27 1991

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARY KLEIN, MD, 1190 N. STATE ROAD 49, CHESTERTON, IN 46304

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D	32 DATE FILED (Month, Day, Year): March 28, 1991

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) CEA CERT/PD 1