PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

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[redacted] Lake 2390 Ujgo 46405

91018293

1 DECEASED—NAME (First, Middle, Last): JOHN SMENYAK
2 SEX: MALE
3a TIME OF DEATH: 9:45P M
3b DATE OF DEATH (Month, Day, Yr): February 20, 1990
4 SOCIAL SECURITY NUMBER: 307-01-5690
5a AGE—Last Birthday (Years): 75
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day Yr): Nov. 15, 1914
7 BIRTHPLACE (City and State or Foreign Country): Martin's Ferry, Ohio
8a WAS DECEDENT A US VETERAN?: N/A
8b YEAR LAST SERVED IN US ARMED FORCES?: -----
8c PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9a FACILITY NAME (If not institution, give street and number): Porter Memorial Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Valparaiso
9d COUNTY OF DEATH: Porter
10 MARITAL STATUS: Married
11 SURVIVING SPOUSE (If wife, give maiden name): Mary Botschazy
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MIllwright
12b KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Lake Station
13d STREET AND NUMBER: 2337 Vermillion
13e ZIP CODE: 46405
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): 10th; College (1-4 or 5+):
18 FATHER'S NAME (First, Middle, Last): John Smenyak Sr.
19 MOTHER'S NAME (First, Middle, Maiden Surname): Ida Zury
20a INFORMANT'S NAME (Type/Print): Mary Smenyak
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6337 Vermillion, Lake Station, IN 46405
20c Relationship: Wife
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): February 23, 1990 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Henry Blake
22b EMBALMER'S LICENSE NO.: FDE1019406
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b LICENSE NUMBER (of Licensee): FDE1001293
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Stilinovich & Wiatrolik FH3004455, 7535 Taft St. Merrillville, IN 46410

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. Cirrhosis
DUE TO (OR AS A CONSEQUENCE OF):
b. Ruptured Esophageal Varices Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Hepatic Encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):
d. Portal Hypertension

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.

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)

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: Kenneth A. Black M.D.
29c. MEDICAL LICENSE NO.: 27841
29d. DATE SIGNED (Month, Day, Year): 2/22/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Kenneth Black, 6040 Lute Road, Portage, Indiana

31. HEALTH OFFICER'S SIGNATURE: Ralph R. Schenker MD
AUDITOR LAKE COUNTY
32. DATE FILED (Month, Day, Year): February 22, 1990

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

Ellista Pk. Lts 1, 2, & N 1/3 Lt 3 Blk 7 #19-108-142

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