91020352

Local No. 624

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.

JUL 27 1988 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: FIRST Catherine MIDDLE M. LAST Rakoczy
2. SEX: Female
3. DATE OF DEATH (Mo. Day Yr.): July 25, 1988
4. SOCIAL SECURITY NUMBER: 310-28-3080
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): Dec 4, 1914
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8. YEAR LAST SERVED IN US ARMED FORCES?
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): 7040 California Avenue
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Frank Rakoczy
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7040 California Avenue
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46323
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):

KEY 32-174-16 L.N. COCKS ADD LOT 15

PARENTS

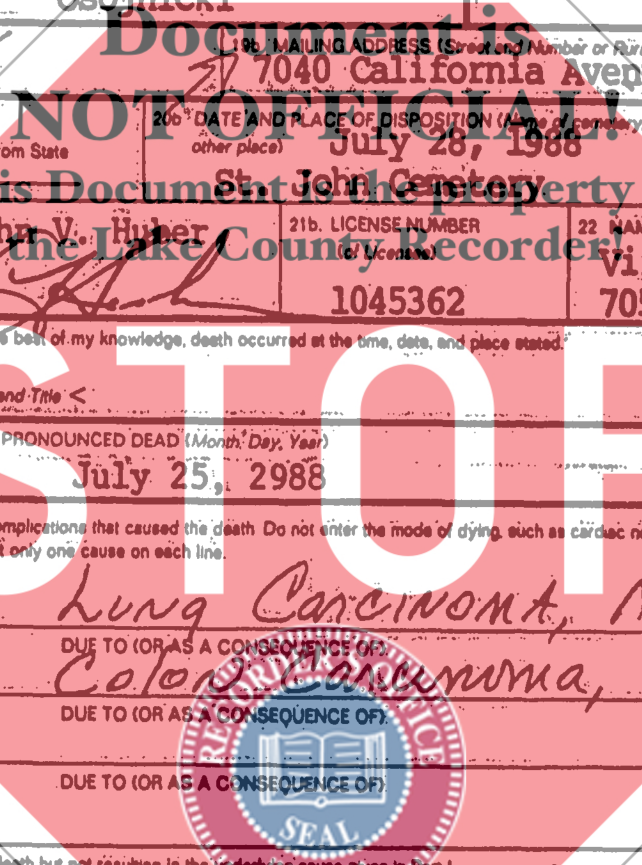
17. FATHER'S NAME (First, Middle, Last): Matt Osojnicki
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Brozovic

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Frank Rakoczy
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7040 California Avenue, Hammond, IN 46323
19c. Relationship: Husband

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 28, 1988 St. John Cemetery
20c. LOCATION—City or Town, State: Hammond, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: John V. Huber [signature]
21b. LICENSE NUMBER (of Licensee): 1045362
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Virgil Huber Funeral Home-3002869, 7051 Kennedy Hammond, IN 46323



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RECORDER'S OFFICE SEAL INDIANA

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 4:50 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year): July 25, 2988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Lung Carcinoma, Metastatic
DUE TO (OR AS A CONSEQUENCE OF):
b. Colon Carcinoma, Primary
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Liver Carcinoma · Diabetes Mellitus, Insulin dependent · Essential Hypertension

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 APR 30 1991
FILED FOR RECORD — RECORDER — LAKE COUNTY, INDIANA — APR 30 9 22 AM '91

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

[signature] AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: William J. Pierce MD [signature]
29c. LICENSE NUMBER: IN 25010
29d. DATE SIGNED (Month, Day, Year): 7/26/88 (JULY 26, 1988)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Dr. William J. Pierce M.D., 8683 Connecticut St., Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin J.O. Fernandez M.D. [signature]
32. DATE FILED (Month, Day, Year): JUL 27 1988

CORONER OR MEDICAL EXAMINER 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)

6.00

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD 1

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