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Key# 15-87-33434
Southlawn Sub
L133 & N.20Ft L132 Blk 11
L134 Blk 11

Local No. 2031-90 91021515

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Josephine A. Gajewski
2. SEX: F
3a. TIME OF DEATH: 5:07 p.m.
3b. DATE OF DEATH (Month, Day, Yr.): October 1, 1990
4. SOCIAL SECURITY NUMBER:
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): Sep 20, 1921
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
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. Anthony's Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Casmir Gajewski
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:
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 5535 Washington St.
13e. ZIP CODE: 46410
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Anthony Panek
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Buchala

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Casmir Gajewski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5535 Washington St. M'ville, In 46410
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Hospital Donation (Name of cemetery, crematory, or other place): Calvary Cemetery
21b. DATE AND PLACE OF DISPOSITION: Oct. 4, 1990
21c. LOCATION—City or Town, State: Portage, In.
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.: FD 01010402
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S Rendina Jr
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina F. Home FH 83007819 5100 Cleveland St. Gary; In 46408

CAUSE OF DEATH

26. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT abbreviate. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Chronic Lymphocytic Leukemia — Approximate Interval Between Onset and Death:

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
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 producing, stated in Part I.

27. WAS DECEDENT PREGNANT, OR 90 DAYS POSTPARTUM? (Yes or No)
28a. WAS AN AUTOPSY PERFORMED? (Yes or No)
28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)

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: R.S. Drasga
29c. MEDICAL LICENSE NO.: 01031484
29d. DATE SIGNED (Month, Day, Year): October 4, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Ray E. Drasga, M.D. 8127 Merrillville Road, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): OCT 9, 90

CORONER 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

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