

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No.

2031-90

91021515

Key# 15-87-334-34

Southlans Sub
433 + N, 20ft 4, 32 Blk
434 Blk
State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

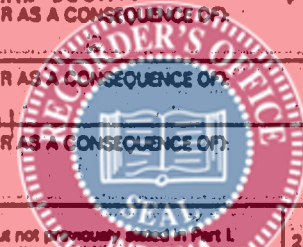
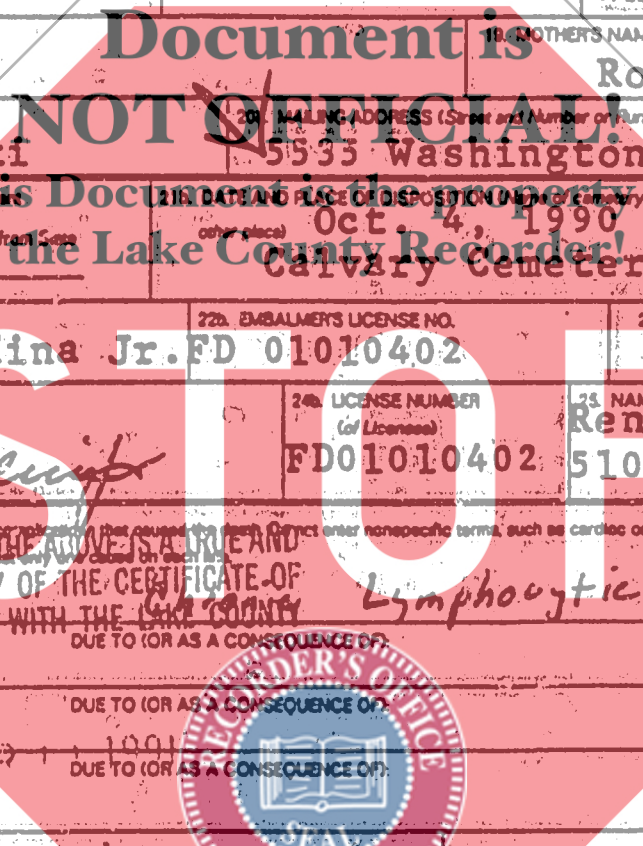
CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1. DECEASED—NAME (First, Middle, Last) Josephine A. Gajewski		2. SEX F		3a. TIME OF DEATH 5:07 p.		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: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> 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 <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-17) 5+					
18. FATHER'S NAME (First, Middle, Last) Anthony Panek				19. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Buchala			
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	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input 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) Oct. 4, 1990 Calvary Cemetery		21c. LOCATION—City or Town, State, Zip Code Portage, Ind.			
22a. EMBALMER'S NAME Anthony S. Rendina Jr.		22b. EMBALMER'S LICENSE NO. FD 01010402		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr.</i>		24b. LICENSE NUMBER (of Licensee) FD01010402		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rendina F. Home FH 83007819 5100 Cleveland St. Gary, In 46408			
25. PART I IMMEDIATE CAUSE (Final disease or condition resulting in death) Lymphocytic Leukemia		25. PART II: Other significant conditions—Conditions contributing to death but not previously stated in Part I					
26. CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last		27. WAR DECEDENT— PREGNANT OR 90 DAYS POSTPARTUM (Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28a. WAS AN AUTOPSY PERFORMED? (Yes or No) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28b. WERE AUTOPSY FINDINGS AVAILABLE FOR REVIEW? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				28c. DATE SIGNED (Month, Day, Year) October 4, 1990	
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>R.S. Drasga</i>		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 20) (Type/Print) Ray E. Drasga, M.D. 8127 Merrillville Road, Merrillville, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Ray E. Drasga</i>						32. DATE FILED (Month, Day, Year) Oct 9, 1990	
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
34d. PERIOD OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
35. DATE PRONOUNCED DEAD (Month, Day, Year)				36. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



FILED
MAY 6 1991