91029182

Local No. 09418-911

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Hobart twp / Gooddwe... E½ E. PT. W½ SW. S. 9 T.36 R. 7 Key # 19-2-16 Unit #14 15cc'd

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	WANDA "BAKALSKI" SMITH
2. SEX	Female
3a. TIME OF DEATH	10:50AM
3b. DATE OF DEATH (Month, Day, Yr)	May 3, 1991
4. SOCIAL SECURITY NUMBER	312-18-2242
5a. AGE—Last Birthday (Years)	66
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	FEB 26, 1925
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?	N/A
9a. PLACE OF DEATH (Check only one)	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	3850 E. 21ST AVE.
9c. CITY, TOWN, OR LOCATION OF DEATH	LAKE STATION
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	JAMES R. SMITH
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY	N/A
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	LAKE STATION
13d. STREET AND NUMBER	3850 E. 21ST AVE.
13e. ZIP CODE	46405
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

18. FATHER'S NAME (First, Middle, Last)	ARTHUR BAKALSKI
19. MOTHER'S NAME (First, Middle, Maiden Surname)	AGNES MALEK

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	JAMES R. SMITH
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3850 E. 21ST AVE., LAKE STATION, IN 46405 (tax mailing address)
20c. Relationship	Husband

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)	MAY 6, 1991 CALVARY CEMETERY
21c. LOCATION—City or Town, State	PORTAGE, INDIANA
22a. EMBALMER'S NAME	JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.	FDO1004194
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FDO1006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 REES FUNERAL HOMES INC. 600 W. OLD RIDGE RD. HOBART, IN 463

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.	Progressive Metastasis 2° to	
DUE TO (OR AS A CONSEQUENCE OF): b.	Cervical Cancer	3/90 →
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

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)	N/A

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.

(Stamp: [signature] CORONER LAKE COUNTY)

29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	01031582
29d. DATE SIGNED (Month, Day, Year)	May 6, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	LYLE R. MUNN MD, 4321 FIR STREET, EAST CHICAGO, IN 46312

HEALTH OFFICER

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

FILED JUN 12 1991

RECORDER'S OFFICE LAKE COUNTY INDIANA

JUN 12 1991 ROBERT J. [illegible] RECORDER

FILED FOR RECORD LAKE COUNTY INDIANA S.S.NO.

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

MAY 06 1991

Alexander S. Williams, M.D. 00762

LAKE COUNTY HEALTH COMMISSIONER

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