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Local No. .....

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.

Oct 18, 1990 Date Issued

Franklin D. Spremulli M.D. Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JOHN JOE PUSCAK
2. SEX: MALE
3a. TIME OF DEATH: 9:23 P.M.
3b. DATE OF DEATH (Month, Day, Yr.): OCTOBER 14, 1990
4. SOCIAL SECURITY NUMBER: 312-30-6594
5a. AGE—Last Birthday (Years): 59
5b. UNDER 1 YEAR Months: Days:
5c. UNDER 1 DAY Hours: Minutes:
6. DATE OF BIRTH (Mo. Day, Yr.): JULY 1, 1931
7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1954
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. MARGARET HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): BARBARA STREET
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MECHANIC
12b. KIND OF BUSINESS/INDUSTRY: CAR REPAIR
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 3922 WABASH AVENUE
13e. ZIP CODE: 46327
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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): THOMAS PUSCAK
19. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH SLAVENIK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): BARBARA PUSCAK
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3922 WABASH AVENUE, HAMMOND, IN 46327
20c. Relationship: WIFE

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): OCTOBER 19, 1990 HOLY CROSS CEMETERY
21c. LOCATION—City or Town, State: CALUMET CITY, ILLINOIS
22a. EMBALMER'S NAME: KEITH D. ANTHONY
22b. EMBALMER'S LICENSE NO: 01011911
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835 4404-CAMERON, HAMMOND, IN 46327

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Severe coronary atherosclerosis.
DUE TO (OR AS A CONSEQUENCE OF):
b. Marked cardiomegaly.
DUE TO (OR AS A CONSEQUENCE OF):
c. Congestion of lungs.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death: Unknown

FILED JAN 10 1992

Anna N. Anton AUDITOR LAKE COUNTY

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): YES
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

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: Daniel D. Thomas M.D.
29c. MEDICAL LICENSE NO.: 16120
29d. DATE SIGNED (Month, Day, Year): October 17, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DANIEL D. THOMAS M.D. 2293 N. MAIN STREET, CROWN POINT, INDIANA 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Spremulli M.D.
32. DATE FILED (Month, Day, Year): OCT 18 1990

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): October 14, 1990
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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