

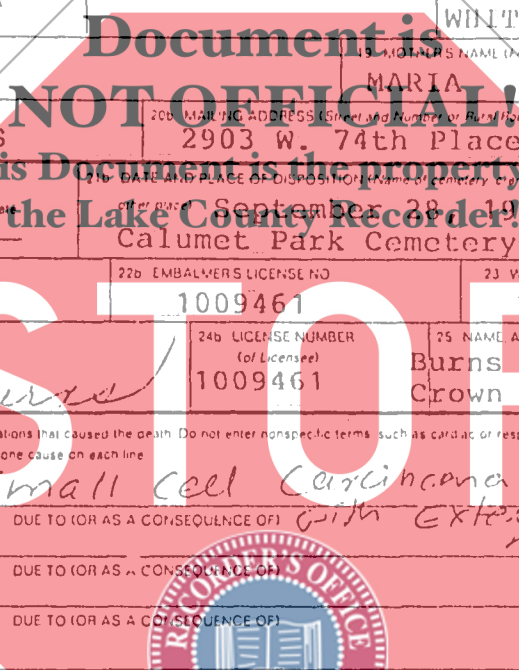
Local No. 1980-91

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (If first Middle Last) <b>DIMITRIOS KYMAKIS</b>		2 SEX <b>MALE</b>		3a TIME OF DEATH <b>5:00 AM</b>		3b DATE OF DEATH (Month Day, Year) <b>SEPTEMBER 26, 1991</b>	
4 SOCIAL SECURITY NUMBER <b>313-34-3041</b>		5a AGE—Last Birthday (Years) <b>73</b>		5b UNDERLYING CAUSE (Months Days Hours Minutes)		6 DATE OF BIRTH (Day, Month, Year) <b>APRIL 5, 1918</b>	
7a WAS DECEASED A U.S. VETERAN? <b>NO</b>		7b EARLIEST SERVED IN U.S. ARMED FORCES?		8 PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> At Home <input type="checkbox"/> Other (Specify) _____			
9a FACILITY NAME (If not institution give street and number) <b>METHODIST HOSPITAL SOUTHLAKE CAMPUS</b>				9b CITY/TOWN OR LOCATION OF DEATH <b>MERRILLVILLE</b>		9c COUNTY OF DEATH <b>LAKE</b>	
10 MARITAL STATUS <b>MARRIED</b>		11 SURVIVING SPOUSE (If wife give maiden name) <b>GEORGIA pappasotirov</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retirement) <b>machinist</b>		12b KIND OF BUSINESS/INDUSTRY <b>U.S. Steel Gary Works</b>	
13a RESIDENCE—STATE <b>INDIANA</b>		13b COUNTY <b>LAKE</b>		13c CITY/TOWN OR LOCATION <b>MERRILLVILLE</b>		13d STREET AND NUMBER <b>2903 W. 74th Place</b>	
13e ZIP CODE <b>46410</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 COUNTRY OF WHAT COUNTRY? <b>USA</b>		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) <b>WHITE</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary, Secondary (K-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		18 FATHER'S NAME (First Middle Last) <b>GEORGE KYMAKIS</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>MARIA ANDREPOPOULES</b>		20a INFORMANT'S NAME (Type/Print) <b>GEORGIA KYMAKIS</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2903 W. 74th Place, Merrillville, IN 46410</b>		20c Relationship <b>WIFE</b>	
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, signature, or other place) <b>September 28, 1991 Calumet Park Cemetery</b>		21c CITY/TOWN/STATE <b>Merrillville Indiana</b>			
22a EMBALMERS NAME <b>James F. Burns</b>		22b EMBALMERS LICENSE NO. <b>1009461</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b LICENSE NUMBER (of Licensee) <b>1009461</b>		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445</b>			
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. <b>Small cell carcinoma of lung with extensive liver metastasis</b>		a DUE TO (OR AS A CONSEQUENCE OF) <b>with extensive liver metastasis</b>		b DUE TO (OR AS A CONSEQUENCE OF)			
c DUE TO (OR AS A CONSEQUENCE OF)		d DUE TO (OR AS A CONSEQUENCE OF)		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>			
28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>		29 DATE FILED (Month Day, Year) <b>Sept. 27, 1991</b>			
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>J. Sanghvi</i>		29c MEDICAL LICENSE NO. <b>NO35695B</b>		29d DATE SIGNED (Month Day, Year) <b>9-26-91</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Jyotsna Sanghvi, M.D. 125 E. 89th Ave. Merrillville, IN 46410</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>							
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>FILED</b>		34f DATE OF INJURY <b>FEB 18 1992</b>			
34g DATE PRONOUNCED DEAD (Month Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <i>Anna N. Anton</i>					



# 15-41624  
Suncoco Gardens 9th St 297

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