6 CC's

# INDIANA STATE BOARD OF HEALTH

Local No. 3307-91 92010131 **CERTIFICATE OF DEATH** State No: .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1. DECEASED—NAME (First, Middle, Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr) |
|---|---|---|---|
| VIOLA K. WACKOWSKI | Female | 2:10 P.M. | December 22, 1991 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR Months / Days | 5c. UNDER 1 DAY Hours / Minutes | 6. DATE OF BIRTH (Mo, Day, Yr) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 312-05-8923 | 90 | | | August 29, 1901 | Poland |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See instructions) |
|---|---|---|
| No | -- | HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| St. Mary Medical Center | Hobart | Lake |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Widowed | ---- | Homemaker | Self |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Gary | 4788 Madison Street |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| 46408 | ☐ No ☒ Yes | ☒ No ☐ Yes | U.S.A. | ☒ No ☐ Yes | White | Elementary/Secondary (0-12): 6 | College (1-4 or 5+): |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Felix Kinasiewicz | Lucy N.A. |

**INFORMANT**

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| Edward Wackowski | 5814 Roosevelt St. Merrillville, In. 46410 | Son |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | December 24, 1991 Calvary Cemetery | Portage, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Alexis Thanos | FD08600505 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Alexis Thanos | FD08600505 | Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410 |

**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. Pneumonia | |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | DUE TO (OR AS A CONSEQUENCE OF) b. | |
| | DUE TO (OR AS A CONSEQUENCE OF) c. | |
| | DUE TO (OR AS A CONSEQUENCE OF) d. | |

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Congestive Heart Failure

| 27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) | 28a. WAS AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|
| No | No | 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 | 29c. MEDICAL LICENSE NO. | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| LAKE COUNTY HEALTH COMMISSIONER Alexander Williams, MD | 1026067 | 1-3-92 |

**HEALTH OFFICER**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Raymundo Billena, M.D., 5490 Broadway, Merrillville, Indiana 46410

31. HEALTH OFFICER'S SIGNATURE Alexander B. Williams, MD

32. DATE FILED (Month, Day, Year) January 6, 1992

**CORONER USE ONLY**

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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. |
|---|---|
| | |

006.11

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



Burke, Murphy, Costanza & Cuppy 610 Gary Natl Bk 565 13th Ave Merrillville 46410-7001