92010270

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0335-92 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): FRANK E. SKALA
2. SEX: Male
3a. TIME OF DEATH: 3:45 A M
3b. DATE OF DEATH (Month, Day, Yr.): February 11, 1992
4. SOCIAL SECURITY NUMBER: 303-24-5840
5a. AGE—Last Birthday (Years): 67
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr.): December 6, 1924
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? 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify if...): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Jane Siminski
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Operator
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 3509 Maryland Street
13e. ZIP CODE: 46409
13f. INSIDE CITY LIMITS? [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Frank Skala
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jesik

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Jane Skala
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3509 Maryland St. Gary, IN 46409
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 14, 1992 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: William D. Smith
22b. EMBALMER'S LICENSE NO.: 9000049
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas L. Pruzin
24b. LICENSE NUMBER (of Licensee): 1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Metastatic Malignant carcinoma

DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma Colon

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

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Renal failure

27. WAS DECEDENT PREGNANT WITHIN PAST YEAR? 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)

AUDITOR LAKE COUNTY

CERTIFIER

29a. CERTIFIER (Check only one): [X] 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: M. Billena Jr MD
29c. MEDICAL LICENSE NO.: 10260 67
29d. DATE SIGNED (Month, Day, Year): 2-11-92

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Raymundo L. Billena, M.D., 5490 Broadway, Merrillville, IN 46410 (219) 887-9549
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): February 12, 1992

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 Ooccurred
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.

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SRH06-004