Local No. 60

92013353

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.

Jun 11 1990 — Franklin D. Fernando M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Andrew Firrek
2 SEX: Male
3a TIME OF DEATH: 10:55 pm
3b DATE OF DEATH (Month Day, Yr): January 16, 1990
4 SOCIAL SECURITY NUMBER: 306-03-5169
5a AGE—Last Birthday (Years): 76
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo Day Yr): Oct. 14, 1913
7 BIRTHPLACE (City and State or Foreign Country): E. Vandergrift, Pa.
8a WAS DECEDENT A U.S. VETERAN?: N/A
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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): Ann Joan Bogolia
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: Steel Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 7607 Jackson
13e ZIP CODE: 46320
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
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): 8; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Joseph Fierek
19 MOTHER'S NAME (First Middle Maiden Surname): Mary Unavailable

INFORMANT

20a INFORMANT'S NAME (Type/Print): Ann Joan Firrek
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7607 Jackson Hammond, Indiana
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): January 20, 1990 Oak Hill Cemetery
21c LOCATION—City or Town, State: Hammond, Indiana
22a EMBALMER'S NAME: Ronald A. Reed
22b EMBALMER'S LICENSE NO: FDO 1001081
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: C.A. Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Highland, Indiana FDH 300-7500

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. Sepsis
DUE TO (OR AS A CONSEQUENCE OF)
b. Malnutrition
DUE TO (OR AS A CONSEQUENCE OF)
c. Pyelonephritis
DUE TO (OR AS A CONSEQUENCE OF)
d. Renal failure

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: Diabetes mellitus

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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): 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: Sirajuddin S. Khaja
29c MEDICAL LICENSE NO: 32657
29d DATE SIGNED (Month, Day, Year): Jan 1/18/90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. Khaja, M.D. 5500 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Fernando M.D.
32 DATE FILED (Month, Day, Year): JAN 19 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):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

Charlotte Gaudstra 933 Hall Ave. Munster

FILED FEB 28 1992

#35-290-2

Lot 2, Block 1, as marked and laid down on the recorded plat of Redivision of Riverview Add. to Hammond, in Lake County, Indiana, as the same appears of record in Plat Book 19, page 31, in the Recorder's Office of Lake County, Indiana.