1 92022080

Local No. 465

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.

MAY 24 1988 — Date Issued

Franklin D. Bermuda M.D. — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First / Middle / Last)			2 SEX	3 DATE OF DEATH (Month, Day, Year)
THADDEUS	A.	CIASTKO	MALE	MAY 22, 1988

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 (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
305-20-3330	62			FEB 10, 1926	CALUMET CITY, ILLINOIS

8 YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one—See instructions)
1946	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
1520 SHELL STREET	HAMMOND	LAKE

10 MARITAL STATUS—Married / Never Married / Widowed / Divorced (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
MARRIED	MARY B. DUDA	CABLE INSPECTOR	STEEL

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	1520 SHELL STREET

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.)	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed)	
YES	NO	46320	☒ No ☐ Yes Specify	WHITE	Elementary/Secondary (0-12)	College (1-4 or 5+)
					12	

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
ANTHONY CIASTKO	JOSEPHINE UNAVAILABLE

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
MARY B. CIASTKO	1520 SHELL STREET, HAMMOND, IN 46320	WIFE

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	MAY 26, 1988 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (Of Licensee)	21c NAME AND ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Kuck D Anthony	1011911	ANTHONY & DZIADOWICZ F.H. 3002835 4404 CAMERON, HAMMOND, IN 46327

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge, death occurred at the time, date, and place stated — Signature and Title	23b LICENSE NUMBER	23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month, Day, Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
6:30 PM	MAY 22, 1988	YES

CAUSE OF DEATH

SEE INSTRUCTIONS

27 PART I — Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardiac arrest

DUE TO (OR AS A CONSEQUENCE OF)

b. Chronic congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF)

c. Ischemic congestive cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF)

d. Prior myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death
0
one year
one year
7 years

APR 10 1992

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a WAS AUTOPSY PERFORMED?	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO

AUDITOR LAKE COUNTY

SEE INSTRUCTIONS

CERTIFIER

29a CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
James B. Walsh	27487	MAY 23, 1988

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

JAMES B. WALSH M.D. 5500 HOHMAN AVENUE, HAMMOND, INDIANA 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Bermuda M.D.	MAY 24 1988

CORONER OR MEDICAL EXAMINER 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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1