

92023949

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

1st Subdiv E Gary h.3 B.16
Key # 19-53-4; unit # 14

600

Local No. ... 0746-92

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) GEORGE DRAGASH		2. SEX MALE	3a. TIME OF DEATH 4:54P_M	3b. DATE OF DEATH (Month, Day, Year) MARCH 31, 1992	
4. SOCIAL SECURITY NUMBER 312-05-9806	5a. AGE—Last Birthday (Years) 77	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) MAY 10, 1914	
7. BIRTHPLACE (City and State or Foreign Country) INDIANA HARBOR, INDIANA	8a. WAS DECEDENT A U.S. VETERAN? NO				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) BUSINESS				
9a. FACILITY NAME (If not institution, give street and number) 2876 DEKALB STREET		9b. CITY, TOWN OR LOCATION OF DEATH LAKE STATION		9c. COUNTY OF DEATH LAKE	
10. MARITAL STATUS: MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) HELEN VARGO	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) FOREMAN		12b. KIND OF BUSINESS/INDUSTRY: REPUBLIC STEEL	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION LAKE STATION		13d. STREET AND NUMBER 611-28th AVE.	
13e. ZIP CODE 46405	13f. INSIDE CITY LIMITS: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) WHITE	
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4 or 5+):		18. FATHER'S NAME (First, Middle, Last) ANDREW DRAGASH			
19. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED TOMIC		20. INFORMANT'S NAME (Type/Print) HELEN DRAGASH			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611-28th AVE, LAKE STATION, IN 46405		20c. Relationship WIFE			
21a. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CALVARY CEMETERY APRIL 3, 1992		21c. LOCATION—City or Town, State PORTAGE, INDIANA	
22a. EMBALMER'S NAME JAMES W. GHOLSTON		22b. EMBALMER'S LICENSE NO. FDO 1004194		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>David C. Mayer</i>		24b. LICENSE NUMBER (of Licensee) FDO1012048		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH 83005613 REES FUNERAL HOME, OLSON CHAPEL 5341 CENTRAL AVE., PORTAGE, IN 46368	
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) 1992		a. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF)			
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause first.		b. <i>Systemic atherosclerotic vascular disease</i> 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) 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	
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>W. G. Sala, M.D.</i>			29c. MEDICAL LICENSE NO. 015348	29d. DATE SIGNED (Month, Day, Year) 4-3-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) WALTER SALA MD, 5490 BROADWAY, MERRILLVILLE, INDIANA 46410					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>				32. DATE FILED (Month, Day, Year) April 3, 1992	
33. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIPTION OF 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, please specify.			

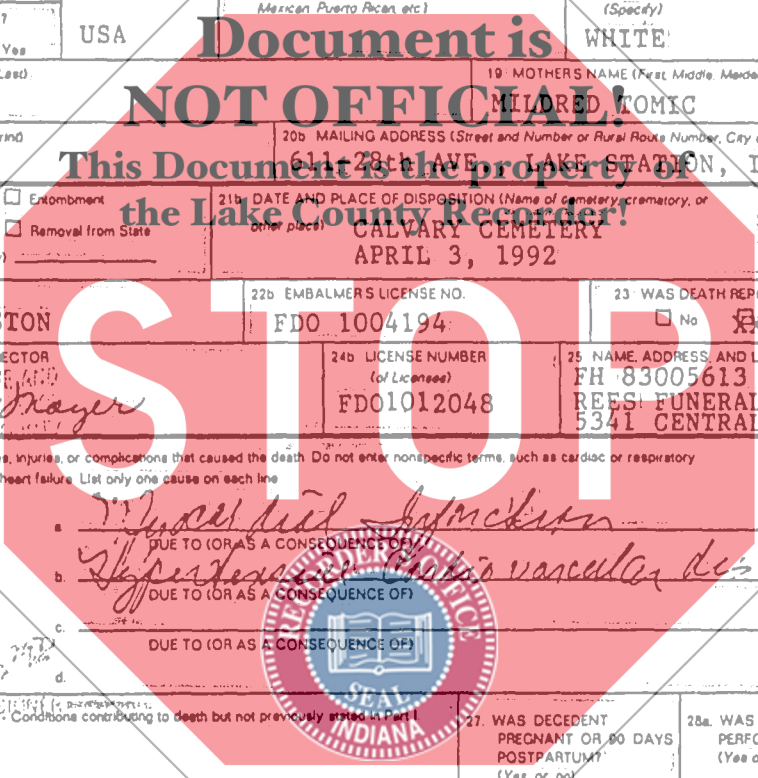
DECEDENT

PARENTS
INFORMANT

DISPOSITION

CAUSE OF DEATH

LAKE



APR 20 3 17 PM 1992
ROBERT E. SALA, RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

FILED

APR 20 1992

David N. Anton
AUDITOR LAKE COUNTY

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