1

Local No. 92037901 008264

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. 91-047395

TYPE/PRINT IN PERMANENT BLACK INK

2 cc

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Samuel A. Capich
2. SEX	Male
3a. TIME OF DEATH	4:45P. M
3b. DATE OF DEATH (Month, Day, Yr.)	December 2, 1991
4. SOCIAL SECURITY NUMBER	399-12-9208
5a. AGE—Last Birthday (Years)	66
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr.)	March 13, 1925
7. BIRTHPLACE (City and State or Foreign Country)	EAST CHICAGO, IN
8a. WAS DECEDENT A US VETERAN?	no
8b. YEAR LAST SERVED IN US ARMED FORCES?	n/a
9a. PLACE OF DEATH (Check only one. See Instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number)	Midwest Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Indianapolis
9d. COUNTY OF DEATH	Marion
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Mary Grzetich
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Machine Operator
12b. KIND OF BUSINESS/INDUSTRY	Valve Company
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Marion
13c. CITY, TOWN OR LOCATION	Indianapolis
13d. STREET AND NUMBER	2525 Fredonia Rd.
13e. ZIP CODE	46222
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes — No
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 10; College (1-4 or 5+):

40700 696

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Samuel Capich
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Mary TOMASICH

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Ann Capich
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2525 Fredonia Rd. Indpls, In. 46222
20c. Relationship	Daughter

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	December 6, 1991 CALVARY CEMETERY
21c. LOCATION—City or Town, State	Indianapolis In.
22a. EMBALMER'S NAME	Gary Jones
22b. EMBALMER'S LICENSE NO.	F008800061
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Doug Mendenhall
24b. LICENSE NUMBER (of Licensee)	FD01005556
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Conkle Funeral Home 4925 W. 16th St. Speedway, In. 46224 FH88006423

CAUSE OF DEATH

QUERIED 0389

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.

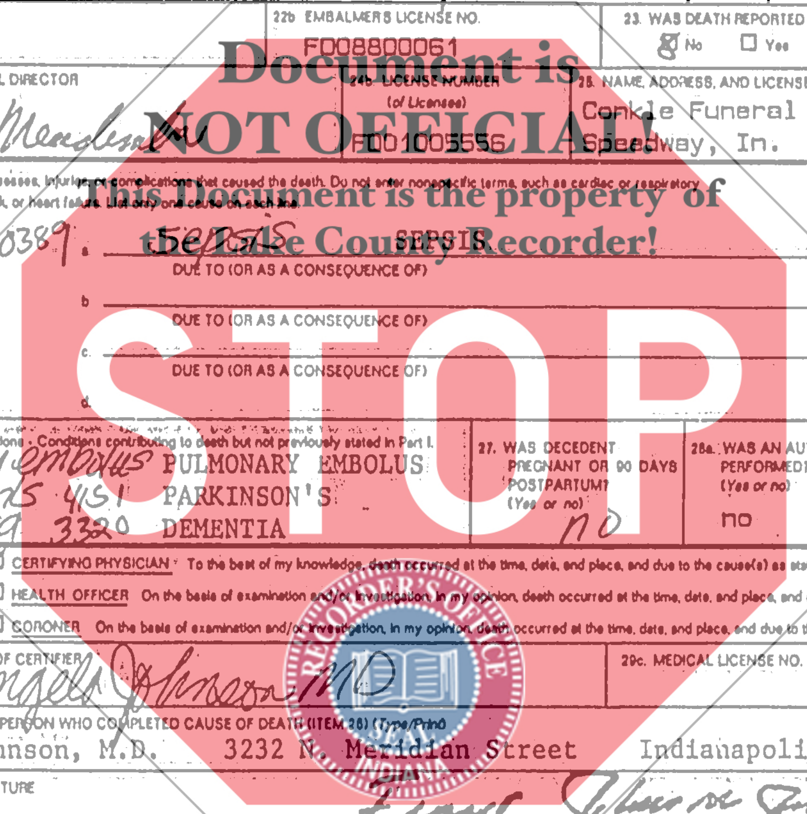
	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	0389. sepsis SEPSIS	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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 resulting in the underlying cause given in Part I.
pulmonary embolus PULMONARY EMBOLUS
Parkinsons 4151 PARKINSON'S
dementia 3320 DEMENTIA

Field	Entry
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)	

Stamp: RECEIVED ... '92 ... 9 33 AM



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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Angela Johnson MD
29c. MEDICAL LICENSE NO.	
29d. DATE SIGNED (Month, Day, Year)	12/5/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Angela Johnson, M.D. 3232 N. Meridian Street Indianapolis, Indiana 46208

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature]
32. DATE FILED (Month, Day, Year)	DEC 6 1991

CORONER USE ONLY

Field	Entry
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.	

SBH06-004 a.i. State Form 10110 (R2/3-89) DEA CERT/PO 1 U.C. DOCTOR STATES UNKNOWN ORGANISM OR UNDERLYING CAUSE

Key #37-166-19
S. 44 Ft. of E. 160 Ft of W. 330 Ft of N. 132 Ft. of S. 528 Ft. of NW 1/4 SE 1/4 S. 9 T. 36 R. 9 .161 Ac.

FILED
JUN 10 1992
Anna N. Antone
AUDITOR LAKE COUNTY

THE ABOVE IS A TRUE COPY OF THE RECORD ON FILE WITH THE INDIANA STATE BOARD OF HEALTH

MAY 15 1992

[signature]

Not valid unless machine signed with multi-colored ribbon
It is unlawful to reproduce this record

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CERTIFICATE
State Form 26217

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