

Key# 43-425-15
Gerrit Add
L15
State No.

92038014

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 1149-92

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Olga R. Stulac		2 SEX Female	3a TIME OF DEATH 8:00A	3b DATE OF DEATH (Month Day, Yr) May 22, 1992
4 SOCIAL SECURITY NUMBER 305-12-9455	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) Jan. 23, 1923
6a WAS DECEDENT A U.S. VETERAN? NO	6b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		

DECEDENT

9b FACILITY NAME (If not institution give street and number) Methodist Hospital-Southlake		9c CITY TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Martin T. Stulac	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife	12b NO OF BUSINESSES/INDUSTRY Self
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 925 E. 51st Place

PARENTS

13e ZIP CODE 46409	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" 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) 12 College (1-4 or 5+)
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INFORMANT

18 FATHER'S NAME (First Middle Last) Peter Adams	19 MOTHER'S NAME (First Middle Maiden Surname) Irene	
20a INFORMANT'S NAME (Type/Print) Martin T. Stulac	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 E. 51st Pl, Gary, IN 46409	20c Relationship Husband

DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 26, 1992 Calumet Park Cemetery, Merrillville, Indiana	21c LOCATION—City or Town, State
22a EMBALMERS NAME David Semplinski	22b EMBALMERS LICENSE NO. FD08600686	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes

CAUSE OF DEATH

24a SIGNATURE OF FUNERAL DIRECTOR Robert Wiatrolik	24b LICENSE NUMBER (of Licensee) FD01001293	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Stilinovich & Wiatrolik FH300445 7535 Taft Merrillville, IN 46410
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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)
DEATH ON FILE WITH THOSE TO TOR AS A CONSEQUENCE OF HEART DISEASE

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

CERTIFIER

PART II. Other significant conditions - Conditions contributing to death but not previously listed in Part I

27. WAS DECEDENT PREPREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)
NO

28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO

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.

HEALTH OFFICER

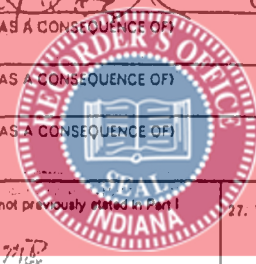
29b SIGNATURE AND TITLE OF CERTIFIER Alexandra Stulac	29c MEDICAL LICENSE NO. 017087	29d DATE SIGNED (Month Day, Year) 5-26-92
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CORONER USE ONLY

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Kolettis 6111 Harrison Merrillville, IN.			
31 HEALTH OFFICER'S SIGNATURE Alexandra Stulac			32 DATE FILED (Month Day, Year) May 28, 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"/> Homicide <input type="checkbox"/> Could not be Determined	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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FILED

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