Key# 43-425-15
Gerrit Add
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92038014

Local No. 1149-92

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Olga R. Stulac
2 SEX: Female
3a TIME OF DEATH: 8:00A M
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
7 BIRTHPLACE (City and State or Foreign Country): Gary, IN.
8a WAS DECEDENT A U.S. VETERAN? NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
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 KIND OF BUSINESS/INDUSTRY: Self
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 925 E. 51st Place
13e ZIP CODE: 46409
13f INSIDE CITY LIMITS [ ] No [X] Yes
13g ON A FARM? [X] 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): 12; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First Middle Last): Peter Adams
19 MOTHER'S NAME (First Middle Maiden Surname): Irene

INFORMANT

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: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 26, 1992 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: David Semplinski
22b EMBALMER'S LICENSE NO.: FD08600686
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
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

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. Cardiac Arrest
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Alexander D. Kollias, MD LAKE COUNTY HEALTH COMMISSIONER
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a WAS 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) 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: Alex Kollias MD
29c. MEDICAL LICENSE NO.: 017057
29d. DATE SIGNED (Month, Day, Year): 5-26-92

HEALTH OFFICER

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: Alexander D. Kollias MD
32 DATE FILED (Month, Day, Year): May 28, 1992

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