INDIANA STATE BOARD OF HEALTH

Local No. 1771-88 — CERTIFICATE OF DEATH — State No. 92040763

1200 D

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First / Middle / Last)	2 SEX	3 DATE OF DEATH (Mo. Day Yr.)
MARY V. KUBACKE	Female	August 26, 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)
317-09-7110	83			3-24-1905	POLAND

8 YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
N/A	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
ST. MARY MEDICAL CENTER	HOBART	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	JOSEPH J. KUBACKE	WAITRESS	KRESGE'S

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HOBART	3756 LIVERPOOL ROAD

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.) ☒ No ☐ Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	NO	46342		WHITE	7	

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
VICTOR PELCZAR (DECEASED)	ANGELINE SMYT (DECEASED)

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
JOSEPH J. KUBACKE	3756 LIVERPOOL ROAD, HOBART, INDIANA 46342	SPOUSE

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)	August 29, 1988 CALUMET PARK CEMETERY	MERRILLVILLE, INDIANA

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Gerald V. Rees	FDE1041083	REES FUNERAL HOME--FDH3003069 46342 600 WEST OLD RIDGE RD., HOBART, IN

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 24-28 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)
12:40P	AUGUST 26, 1988	NO

CAUSE OF DEATH

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. Approximate Interval Between Onset and Death

SEE INSTRUCTIONS

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. cerebroma of cylon with metastasis

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

DUE TO (OR AS A CONSEQUENCE OF)

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

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

28a WAS AN AUTOPSY PERFORMED? (Yes or 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 (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)
Donald M. Phillips M.D.	0102846	8/29/88

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
DONALD PHILLIPS M.D., 1356 S. LAKE PARK AVE., HOBART, IN 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE — 31a DATE FILED (Month, Day, Year) August 29, 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)

0111?

SBH08-004 State Form 10110 Rev. 10/87 DEATH/PD 1

MAIL TO: GERALD M. BISHOP, ESQ., GRECO, PERA & BISHOP, 2115 W. Lincoln Highway Merrillville, IN 46410