1 Hyde Park Add L.9 Bl.H Key#34-156-9
Unit#26

Local No. 555
92041629

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

June 22, 1992 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Geraldine B Doniak
2 SEX: Female
3a TIME OF DEATH: 12:39 A
3b DATE OF DEATH (Month Day Yr): June 20, 1992
4 SOCIAL SECURITY NUMBER: 314-05-7395 B
5a AGE—Last Birthday (Years): 67
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): May 9, 1925
7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
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: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): John Doniak
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: Homemaker
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 6428 Harrison Ave.
13e ZIP CODE: 46324
13f INSIDE CITY LIMITS: ☐ No XX Yes
13g ON A FARM?: XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN?: XX 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 years; College (1-4 or 5+): --

PARENTS

18 FATHER'S NAME (First Middle Last): Spencer Lind
19 MOTHER'S NAME (First Middle Maiden Surname): Mabel Hoffman

INFORMANT

20a INFORMANT'S NAME (Type/Print): John Doniak
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6428 Harrison Ave., Hammond, Indiana 46324
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 23, 1992 Concordia Cemetery
21c LOCATION—City or Town, State: Hammond, Indiana
22a EMBALMER'S NAME: Charles W. Wells
22b EMBALMER'S LICENSE NO: #1042372
23 WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD#1004097
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH#83002893 7109 Calumet Ave., Hammond, Ind. 46324

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. [handwritten]
DUE TO (OR AS A CONSEQUENCE OF):
b. [handwritten]
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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 previously stated in Part I

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

ROBERT ... JUN 29 10 59 AM '92 ... RECORDER

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
29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 01035532
29d DATE SIGNED (Month, Day, Year): June 21, 1992
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. S. Salgan 13419 S. Baltimore Chicago, Illinois 60633

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month, Day, Year): June 22, 1992

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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.

FILED JUN 29 1992
[signature] AUDITOR LAKE COUNTY

01889

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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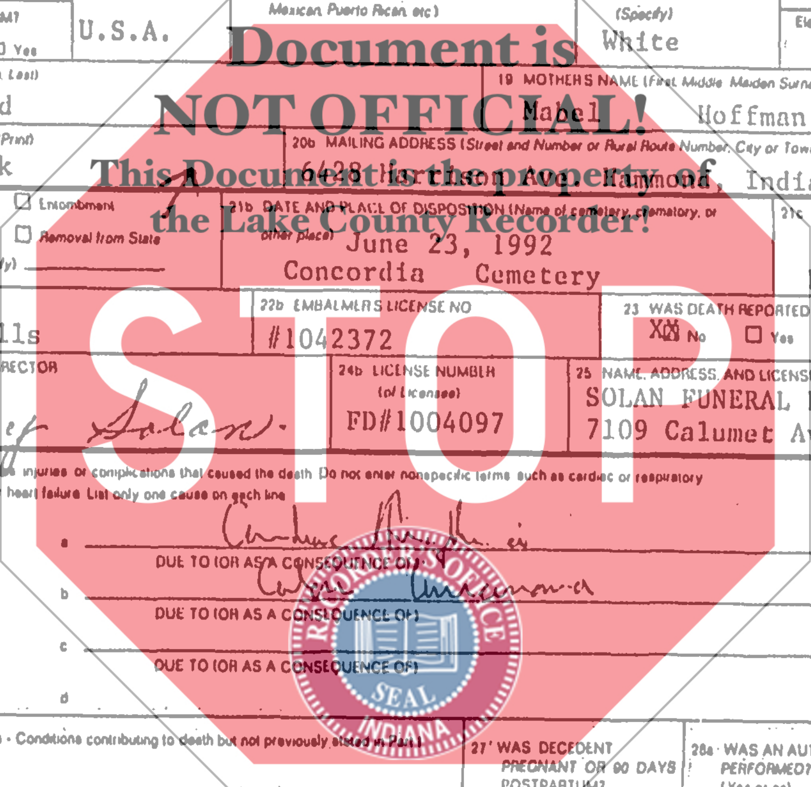

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