

92042031

INDIANA STATE BOARD OF HEALTH  
CORONER'S CERTIFICATE OF DEATH

State No. ....

FILE NO. L4863  
TYPE OR PRINT  
PLAINLY WITH  
UNFADING INK  
THIS IS A  
PERMANENT  
RECORD

Local No. 1454-85

TYPE OR PRINT  
IN PERMANENT  
INK FOR  
INSTRUCTIONS  
SEE  
HANDBOOK

DECEASED

IF DEATH  
OCCURRED IN  
INSTITUTION,  
SEE HANDBOOK  
REGARDING  
COMPLETION OF  
RESIDENCE ITEMS

PARENTS

DISPOSITION

CERTIFIER

CONDITIONS  
IF ANY  
WHICH GAVE  
RISE TO  
IMMEDIATE  
CAUSE  
STATING THE  
UNDERLYING  
CAUSE LAST

CAUSE

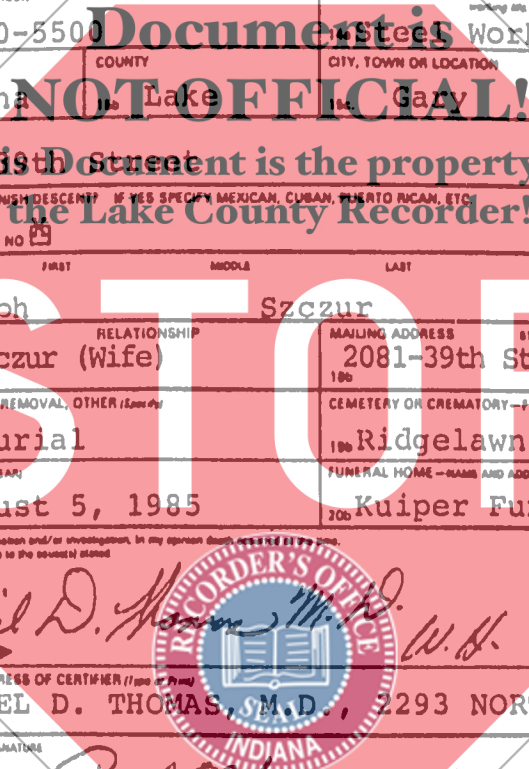
FUNERAL HOME  
No. 750  
FUNERAL DIRECTOR'S  
LICENSE No. 1985  
FUNERAL DIRECTOR'S  
LICENSE No. 1984  
James Slacian  
FUNERAL DIRECTOR'S  
SIGNATURE

1. DECEASED—NAME FIRST MIDDLE LAST <b>EDWARD SZCZUR</b>		SEX <b>Male</b>	DATE OF DEATH (MONTH, DAY, YEAR) <b>August 1, 1985</b>
2. RACE—(a) g. White, Black, American Indian, etc. (Specify) <b>White</b>	AGE—Last Birthday (Mo., Day) <b>71</b>	3. UNDER 1 YEAR MOB DATE	4. UNDER 1 DAY HOURS MIN
5. CITY, TOWN OR LOCATION OF DEATH <b>Munster</b>		6. HOSPITAL OR OTHER INSTITUTION—(Name # not in both a, give street and number) <b>Community Hospital</b>	7. IF HOSP OR INST include DCA OP/Emer. Inv. (Specify) <b>E.R.</b>
8. STATE OF BIRTH # not in U.S.A. name country <b>Illinois</b>	9. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	11. SURVIVING SPOUSE # not in both a, give maiden name <b>Anne Bobrowski</b>
12. SOCIAL SECURITY NUMBER <b>322-10-3500</b>		13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>	14. KIND OF BUSINESS OR INDUSTRY <b>Wisconsin Steel Co.</b>
15. RESIDENCE—STATE <b>Indiana</b>	16. COUNTY <b>Lake</b>	17. CITY, TOWN OR LOCATION <b>Gary</b>	18. IS RESIDENCE ON A FARM? 18a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19. STREET AND NUMBER <b>2081 39th Street</b>		19b. IN CITY LIMITS—(Specify Yes or No) <b>No</b>	
20. IF DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 20a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. FATHER—NAME FIRST MIDDLE LAST <b>Joseph Szczur</b>		22. MOTHER—MAIDEN NAME FIRST MIDDLE LAST <b>Mary (Unknown)</b>	
23. INFORMANT—(NAME RELATIONSHIP) <b>Anne Szczur (Wife)</b>		24. MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP <b>2081-39th St., Gary, Indiana 46322</b>	
25. BURIAL, CREMATION, REMOVAL, OTHER (Specify) <b>Burial</b>		26. CEMETERY OR CREMATORY—FUNERAL HOME LOCATION CITY OR TOWN STATE <b>Ridgelawn Cemetery Gary, Indiana</b>	
27. DATE (MONTH, DAY, YEAR) <b>August 5, 1985</b>		28. FUNERAL HOME—(NAME AND ADDRESS) STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP <b>Kuiper Funeral Home, 9039 Kleinman, Highland, IN 46322</b>	
29. On the basis of examination and/or investigation, in my opinion death was due to: (See and place and due to the nearest stated) <b>Severe coronary atherosclerosis with complete occlusion of left coronary artery; Acute myocardial infarction; Cardiomegaly.</b>		30. DATE SIGNED (Mo., Day, Yr.) <b>8-2-85</b>	31. HOUR OF DEATH <b>11:25 P.</b>
32. SIGNATURE <b>Daniel D. Thomas, M.D.</b>		33. PRONOUNCED DEAD (Mo., Day, Yr.) <b>8-1-85</b>	34. AT <b>M</b>
35. NAME AND ADDRESS OF CERTIFIER (If not a Print) <b>DANIEL D. THOMAS, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN. 46307</b>		36. DATE RECEIVED BY LOCAL HEALTH OFFICER <b>8-2-85</b>	
37. HEALTH OFFICER—SIGNATURE <b>Paul Johnson</b>		38. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) <b>Severe coronary atherosclerosis with complete occlusion of left coronary artery; Acute myocardial infarction; Cardiomegaly.</b>	
39. PART I (a) <b>Severe coronary atherosclerosis with complete occlusion of left coronary artery; Acute myocardial infarction;</b>		Interval between onset and death <b>Undetermined</b>	
(b) <b>Cardiomegaly.</b>		Interval between onset and death	
40. PART II OTHER SIGNIFICANT CONDITIONS—(Conditions came during to death but not reported to cause given in PART I (a))		41. AUTOPSY (Specify Yes or No) <b>Yes</b>	
42. ACC. SUICIDE, HOM., UNDET. OR PENDING INVEST (Specify) <b>Natural</b>	43. DATE OF INJURY (Mo., Day, Yr.) <b>26b</b>	44. HOUR OF INJURY <b>26c M</b>	45. DESCRIBE HOW INJURY OCCURRED <b>26d</b>
46. INJURY AT WORK (Specify Yes or No)	47. PLACE OF INJURY—(At home, farm, street, factory, office building, etc. (Specify)) <b>26e</b>	48. LOCATION <b>26g</b>	49. STREET OR R.F.D. NO. CITY OR TOWN STATE

01154

**FILED**  
JUN 26 1992  
AUG 2 1985  
James Slacian  
FUNERAL DIRECTOR'S SIGNATURE

Disposition Permit Issued / /  
Provisions Certificate  
 Yes  No



*W.C.M.*