92053413

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1637-92 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Marko Rados
2 SEX: Male
3a TIME OF DEATH: 11:09A
3b DATE OF DEATH (Month Day Yr): August 1, 1992
4 SOCIAL SECURITY NUMBER: 306-34-0663
5a AGE—Last Birthday (Years): 83
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): May 11, 1909
7 BIRTHPLACE (City and State or Foreign Country): Yugoslavia
8a WAS DECEDENT A US VETERAN? NO
8b YEAR LAST SERVED IN US ARMED FORCES? NONE
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c CITY, TOWN OR LOCATION OF DEATH: Hobart
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Anna Vidakovic
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired):
12b KIND OF BUSINESS/INDUSTRY: Budd Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Lake Station
13d STREET AND NUMBER: 2033 Riverside Drive
13e ZIP CODE: 46405
13f INSIDE CITY LIMITS ☐ No ☐ Yes
13g ON A FARM? ☐ 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): Lazar Rados
19 MOTHER'S NAME (First Middle Maiden Surname): Marta

INFORMANT

20a INFORMANT'S NAME (Type/Print): Anna Rados
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2033 Riverside Dr, Lake Station, IN. 46405
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): August 6, 1992
21c LOCATION—City or Town State: Calumet Park Cemetery Merrillville, IN.
22a EMBALMER'S NAME: David Semplinski
22b EMBALMER'S LICENSE NO: FD08600686
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Robert C. Wiatrolik
24b LICENSE NUMBER (of Licensee): FD01001293
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Stilinovich & Wiatrolik 7535 Taft St. Merrillville, IN. FH30004455

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF): b. Coronary thrombosis
DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions if any, which gave rise to the immediate cause, stating the underlying cause last: AUG 03 1992

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Osteoarthritis severe

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

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: Robert A. Penn, M.D.
29c MEDICAL LICENSE NO: 0101 7915
29d DATE SIGNED (Month, Day, Year): 8-3-92
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Penn 3820 Central Avenue Lake Station, IN. 46405

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander Williams, M.D.
32. DATE FILED (Month, Day, Year): August 3, 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 Ooccurred:
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): AUG 21 1992
34h MOTOR VEHICLE ACCIDENT? (Yes or no, specify driver, passenger, pedestrian):

AUDITOR LAKE COUNTY

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