3cc

93011002 INDIANA STATE DEPARTMENT OF HEALTH

Local No. 93-0087

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): SARA SALLY KOSANOVICH
2 SEX: FEMALE
3a TIME OF DEATH: 7:00P M
3b DATE OF DEATH (Month Day Yr): JANUARY 26, 1993
4 SOCIAL SECURITY NUMBER: 313-07-9003
5a AGE—Last Birthday (Years): 84
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day Yr): JAN. 28, 1903
7 BIRTHPLACE (City and State or Foreign Country): YUGOSLAVIA
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 ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c CITY, TOWN OR LOCATION OF DEATH: GARY
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): WIDOWED
11 SURVIVING SPOUSE (If wife, give maiden name): NONE
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOME MAKER
12b KIND OF BUSINESS/INDUSTRY: SELF
13a RESIDENCE—STATE: IN.
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: GARY
13d STREET AND NUMBER: 7745 Locust Avenue
13e ZIP CODE: 46403
13f INSIDE CITY LIMITS: ☐ No ☐ 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 College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): MILOS TODOROVICH
19 MOTHER'S NAME (First Middle Maiden Surname): ULA MILASEVIC

INFORMANT

20a INFORMANT'S NAME (Type/Print): JUNE KOSANOVICH
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7745 Locust Avenue Gary, IN. 46403
20c Relationship: DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JANUARY 29, 1993 CALUMET PARK CEMETERY
21c LOCATION—City or Town, State: MERRILLVILLE, IN.
22a EMBALMER'S NAME: DAVID SEMPLINSKI
22b EMBALMER'S LICENSE NO: FD08600686
23 WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b LICENSE NUMBER (of Licensee): FD01001293
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH3004455 STILINOVICH & WIATROLIK 7535 TAFT ST. MERRILLVILLE, IN.

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. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. complete heart block
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
c. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

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: 01030560
29d DATE SIGNED (Month, Day, Year): 2-2-93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. GARLAPATI 61st HARRISON STREET MERRILLVILLE, IN. 980-5566

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month, Day, Year): FEB. 8 1993

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.

00997
600

Stamps: FILED FEB 18 1993 [signature] AUDITOR LAKE COUNTY; RECORDED FEB 18 1993; STATE OF INDIANA LAKE COUNTY FILED

46-93-1 Norcotts Add In City all of 1 & 2 & 10 ft of 3 & W 1/2 Vac Pike St Adj (Block 6) 2/18/93 jf

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER-PD 1

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE FEB. 8 1989