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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFICATE [illegible] NG IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No: 12

S Date Issued: Jan. 6, 1993

Hammond Health Commissioner

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): John Laskarin
2. SEX: Male
3a. TIME OF DEATH: 6:00 AM
3b. DATE OF DEATH (Month, Day, Yr): January 5, 1993
4. SOCIAL SECURITY NUMBER: 313-14-9242
5a. AGE—Last Birthday (Years): 66
5b. UNDER 1 YEAR — Months / Days:
5c. UNDER 1 DAY — Hours / Minutes:
6. DATE OF BIRTH (Mo. Day, Yr): May 26, 1926
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A US VETERAN?: yes
8b. YEAR LAST SERVED IN US ARMED FORCES?: 1946
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XX ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): 835-170th Street
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): Margaret (Prosco)
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pipefitter
12b. KIND OF BUSINESS/INDUSTRY: Inland Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 835 - 170th Street
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS? ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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 yrs; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Anthony Laskarin
19. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Catherine Sherlock

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Margaret Laskarin
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 835 - 170th St., Hammond, Ind. 46320
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 7, 1993 St. John Cemetery
21c. LOCATION—City or Town, State: Hammond Indiana
22a. EMBALMER'S NAME: Anthony Solan
22b. EMBALMER'S LICENSE NO.: #1051840
23. WAS DEATH REPORTED TO CORONER? ☐ No XX Yes
24a. SIGNATURE OF FUNERAL DIRECTOR OR AGENT: Anthony Solan
24b. LICENSE NUMBER (of Licensee): #1051840
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME, #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:

a. IMMEDIATE CAUSE (Final disease or condition resulting in death): acute Cardio-Pulmary failure
b. 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: DUE TO (OR AS A CONSEQUENCE OF):

PART II — Other significant conditions. Conditions contributing to death but not previously stated in PART I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POST PREGNANT? (Yes or no): no
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): none
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): none

CERTIFIER

29a. CERTIFIER (Check only one):
XX 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, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel N. T. Wong
29c. MEDICAL LICENSE NO.: 17838 IN
29d. DATE SIGNED (Month, Day, Year): January 5, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Sami N. T. Wong, M.D. 6642 Calumet Ave., Hammond, Ind. 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Jeanuda M.D.
32. DATE FILED (Month, Day, Year): January 6, 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.:

SD106 004 State Form 10110 (R3 / 3-92)

FUNERAL HOME COPY

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