E. 660 ft of W. 1316.56 ft of N. 615.56 ft of N 1/2 SW
S. 12 T. 34 R. 10
Key # 6-62-39; unit #05

Local No. 1105-92

93014309

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Milena Nikolic
2. SEX: Female
3a. TIME OF DEATH: 1:20 pm
3b. DATE OF DEATH (Month, Day, Yr): May 20, 1992
4. SOCIAL SECURITY NUMBER: 359-34-0756
5a. AGE—Last Birthday (Years): 52
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 7, 1940
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? -----
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Anthony Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Milan Nikolic
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Disability
12b. KIND OF BUSINESS/INDUSTRY: Disability
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Dyer
13d. STREET AND NUMBER: 15515 W. 113th Street
13e. ZIP CODE: 46311
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 Yrs; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Svetomir Maksovic
19. MOTHER'S NAME (First, Middle, Maiden Surname): Slavka N/A

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Milan Nikolic
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15515 W. 133th St., Dyer, Indiana 46311
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 22, 1992 Mother of God
21c. LOCATION—City or Town, State: Third Lake, Illinois
22a. EMBALMER'S NAME: James F. Porras
22b. EMBALMER'S LICENSE NO.: 1045964
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James Porras
24b. LICENSE NUMBER (of Licensee): 1045964
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #3002819, 5840 Hohman Ave., Hammond, Ind. for Kompare F.H. Chicago, Ill.
26. DATE: MAY 22 1992

CERTIFIED TO BE A TRUE AND COMPLETE COPY OF CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPT.

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED FOR RECORD
MAR 4 12 PM '93
RECORDER
STATE OF INDIANA LAKE COUNTY FILED

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. carcinoma of breast
DUE TO (OR AS A CONSEQUENCE OF):
b. with metastases
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, which gave rise to immediate cause. Enter 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

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: Nadezda Djurovic
29c. MEDICAL LICENSE NO.: 26620
29d. DATE SIGNED (Month, Day, Year): 5 22 92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Jurovic, 2105 W. Lincoln Highway, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): May 22, 1991

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

FILED
MAR 4 1993
Auditor signature
AUDITOR LAKE COUNTY

00305

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

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