INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 257 93017317 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Joe Andrew Jakubowicz	Male	1:25p.M	September 2,1992

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
310-22-3020	68	1 16		July 16,1924	East Chicago,Indiana

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
Yes	1946	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XX Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
4933 Wegg Ave.	East Chicago	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Julia V.Kaminsky	Engineer-Water Dept.	City of East Chicago

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	East Chicago	4933 Wegg Ave.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN?	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46312	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	XX No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	White	12th grade	4 yrs.

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Andrew Jakubowocz	Maryana Janick

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Mrs. Julia V.Jakubowicz	4933 Wegg Ave.,East Chicago,Ind. 46312	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c LOCATION—City or Town, State
XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	September 5,1992 St. John Cemetery	Hammond,Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
E. Eugene Johnson	FDE-1044968	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
E. Eugene Johnson	FDE-1044968	Huber's Funeral Home-FHD-3001538 905 W. Chicago Ave.,East Chgo.,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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. carcinoma of the colon metastatic to liver — Approximate Interval Between Onset and Death: 6 weeks

DUE TO (OR AS A CONSEQUENCE OF)

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

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

FILED MAR 18 1993 [signature] AUDITOR LAKE COUNTY

SARAH J. ... RECORDER MAR 18 1 53 PM '93 STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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	29c MEDICAL LICENSE NO.	29d DATE SIGNED (Month, Day, Year)
[signature]	01036259	Sept 03 1992

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

J. H Gleaton M.D. 7505 Calumet Ave Munster Ind.

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
[signature]	9-3-92

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 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

Cal Bell & Hoffmann 30-178-32,33,34 ... 34,35,36

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