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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0488-93

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): VICTOR HENIK
2. SEX: Male
3a. TIME OF DEATH: 9:15 p M
3b. DATE OF DEATH (Month, Day, Yr): March 3, 1993
4. SOCIAL SECURITY NUMBER: 306-09-2039
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): November 17, 1915
7. BIRTHPLACE (City and State or Foreign Country): Canada
8a. WAS DECEDENT A U.S. VETERAN?: yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient; ☐ ER/Outpatient; ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake Campus
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Helen S. Drozdal
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): First Helper
12b. KIND OF BUSINESS/INDUSTRY: US Steel Comapany
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Merrillville
13d. STREET AND NUMBER: 5413 Buchanan Street
13e. ZIP CODE: 46410
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; College (1-4 or 5+)?:

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Henik
19. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Walek

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Helen S. Henik
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5413 Buchanan St., Merrillville, Indiana 46410
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): March 6, 1993 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO.: 1042372
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas L. Pruzin
24b. LICENSE NUMBER (of Licensee): 1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 4641

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): N.O.V. Myocardial Congestive heart failure
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

MAR 08 1993

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

27. WAS DECEDENT PREGNANT WITHIN ONE YEAR PRIOR TO DEATH OR 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 25 1993
AUDITOR LAKE COUNTY

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 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: Nazzal Obaid M.D.
29c. MEDICAL LICENSE NO: 010176 21
29d. DATE SIGNED (Month, Day, Year): 3-5-93

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Nazzal Obaid, M.D., 8895 Broadway, Merrillville, IN 46410
31. HEALTH OFFICER'S SIGNATURE: Alexander L. Williams MD
32. DATE FILED (Month, Day, Year): March 3 1993

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.

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

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