

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DATA ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

DEC 03 1991 [Signature]

Date Issued Hammond Health Commissioner

Local No. 972

93027914

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) JOSEPH J. VAVREK		2 SEX MALE	3a TIME OF DEATH 1 PM	3b DATE OF DEATH (Month Day Year) NOVEMBER 29, 1991	
4 SOCIAL SECURITY NUMBER 314-26-8203	5a AGE—Last Birthday (Year) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) MARCH 13, 1928	
7 BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA	8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1950	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution give street and number) 4030 HENRY AVENUE		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) HELEN STRZELEC	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) TRUCK DRIVER		12b KIND OF BUSINESS/INDUSTRY STEEL	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION HAMMOND	13d STREET AND NUMBER 4030 HENRY AVENUE		
13e ZIP CODE 46327	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (11.4 or 5+)		18 FATHER'S NAME (First Middle Last) JOHN VAVREK			
19 MOTHER'S NAME (First Middle Maiden Surname) HELEN GAVALA		20a INFORMANT'S NAME (Type/Print) HELEN VAVREK			
20b MAKING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4030 HENRY AVENUE, HAMMOND, IN 46327		20c Relationship to Decedent WIFE			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CALUMET PARK CEMETERY		21c LOCATION—City or Town, State MERRILLVILLE, INDIANA	
22a EMBALMER'S NAME KEITH D. ANTHONY		22b EMBALMER'S LICENSE NO. 01011911	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes H 93		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D Anthony</i>		24b LICENSE NUMBER (of Licensee) 01011911	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, IN 46327		
26 PART I Enter the disease, 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. refractory metastatic lymphoma DUE TO (OR AS A CONSEQUENCE OF)				Approximate Interval Between Onset and Death 18 months	
IMMEDIATE CAUSE (Final disease or condition resulting in death)					
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 listed 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	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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 <i>[Signature]</i>		29c MEDICAL LICENSE NO. 01036259	
29d DATE SIGNED (Month Day Year) 12-02-91		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) J. H. GLEATON M.D. 7905 CALUMET AVENUE, MUNSTER, INDIANA 46321			
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month Day Year) December 3, 1991		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY MAY 3 1993	34c INJURY AT WORK? (Yes or no)	
34d PLACE OF INJURY—At home, farm, street, factory, office building etc (Specify) <i>[Signature]</i>		34e 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, a driver's license shall be issued. NEVER WAS DRIVING		00005	



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 Hammond City, Ind. add

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