KRYSTYNA JARSKI Key # 17-26-17, unit #27
813 MAIN ST Pt of NE 1/4 of SW 1/4 S. 32 T 36 R. 7 D.943AC
HOBART, IN

10 cc's

INDIANA STATE DEPARTMENT OF HEALTH

Geo. & Wm Forles 2nd Sub Lot 1, Block 10

Local No: 0387-23 93028329 CERTIFICATE OF DEATH

State No. Key #17-133-1, unit #27

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (Fst, Middle, Last): CHESTER JARSKI
2 SEX: Male
3a TIME OF DEATH: 1:22A
3b DATE OF DEATH (Month Day Yr): February 21, 1993
4 SOCIAL SECURITY NUMBER: 308-32-3528
5a AGE—Last Birthday (Years): 81
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): AUG 20, 1911
7 BIRTHPLACE (City and State or Foreign Country): LUBLEN, POLAND
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c CITY TOWN OR LOCATION OF DEATH: HOBART
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): KRYSTYNA MALCZEWSKA
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: U.S. STEEL
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: HOBART
13d STREET AND NUMBER: 813 MAIN STREET
13e ZIP CODE: 46342
13f INSIDE CITY LIMITS?: [ ] No [X] Yes
13g ON A FARM?: [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 9; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): PETER JARSKI
19 MOTHER'S NAME (First, Middle, Maiden Surname): MAGDALENA GUMMIEK

INFORMANT

20a INFORMANT'S NAME (Type/Print): KRYSTYNA JARSKI
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 813 MAIN STREET, HOBART, INDIANA
20c. Relationship: Wife

tax mailing address

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEB 23, 1993 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b EMBALMER'S LICENSE NO: FD01006463
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD1006463
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342

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): THIS CERTIFICATE IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPT. — Approximate Interval Between Onset and Death: 1 day

DUE TO (OR AS A CONSEQUENCE OF): Duodenal Ulcer with Severe Bleeding

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: FEB 23 1993

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: 1) Atherosclerotic Heart Disease 2) Chronic Obstructive Pulmonary Disease

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): N/A
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):
[X] 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: John Scully MD
29c MEDICAL LICENSE NO: 17641
29d DATE SIGNED (Month, Day, Year): 2-23-93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOHN SCULLY MD, 8895 BROADWAY, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander L. Williams, M.D. FILED
32. DATE FILED (Month, Day, Year): February 23, 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: MAY 4 1993
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): James R. Carter CORONER LAKE COUNTY
34g DATE PRONOUNCED DEAD (Month, Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian:

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