

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
Geo. Wm Earles 2nd
Sub lot 1, Block 10

Local No. ... 0387-23... 92028329 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

1 DECEASED—NAME (First, Middle Last) CHESTER		2 SEX JARSKI 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) LUBLIN, 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 <input checked="" type="checkbox"/> Impatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> 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 Married		11 SURVIVING SPOUSE KRYSTYNA MALCZEWSKA		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) PIPE FITTER	
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		14 CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEDENT OF HISPANIC ORIGIN? <input 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 (Specify) 9 Secondary 12 College (4 or 5 +) 3	
18 FATHER'S NAME (First, Middle, Last) PETER JARSKI			19 MOTHER'S NAME (First, Middle, Maiden Surname) MAGDALENA GUMMIEK		
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
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Military, crematory, or other) 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b LICENSE NUMBER (of Licensee) FD01006463		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342	
26 PART I: THIS CERTIFICATE IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDED THE DECEASED OR BY THE PHYSICIAN WHO FIRST EXAMINED THE DECEASED. Enter the disease, injury, or complication 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. COMPLETE COPY OF THIS CERTIFICATE TO BE FURNISHED TO THE LAKE COUNTY HEALTH DEPARTMENT. IMMEDIATE CAUSE WITH THE LAKE COUNTY HEALTH DEPARTMENT. DUE TO (OR AS A CONSEQUENCE OF) Duodenal Ulcer with Severe Bleeding DUE TO (OR AS A CONSEQUENCE OF) FEB 23 1993 DUE TO (OR AS A CONSEQUENCE OF)					
26 PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. 1) Hypertension, 2) Chronic Obstructive Pulmonary Disease LAKE COUNTY HEALTH DEPARTMENT, SURVEILLANCE SECTION					
27 WAS DECEDENT PREGNANT OR 30 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	
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>John T. Scully, MD</i>				29c MEDICAL LICENSE NO. 17624	
29d DATE SIGNED (Month Day Year) 2 23 1993					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) JOHN SCULLY MD, 8895 BROADWAY, MERRILLVILLE, INDIANA 46410					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>				32 DATE FILED (Month Day Year) February 23, 1993	
33 MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year) MAY 4 1993		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) Home	
34f LOCATION (Street and Number or Rural Route Number, City or Town, State) Home		34g DATE PRONOUNCED DEAD (Month Day Year)			
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger bicyclist, etc.					

DECEDENT

PARENTS

INFORMANT

tax mailing address

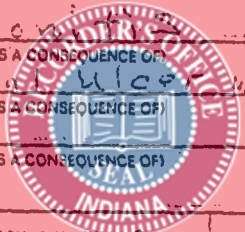
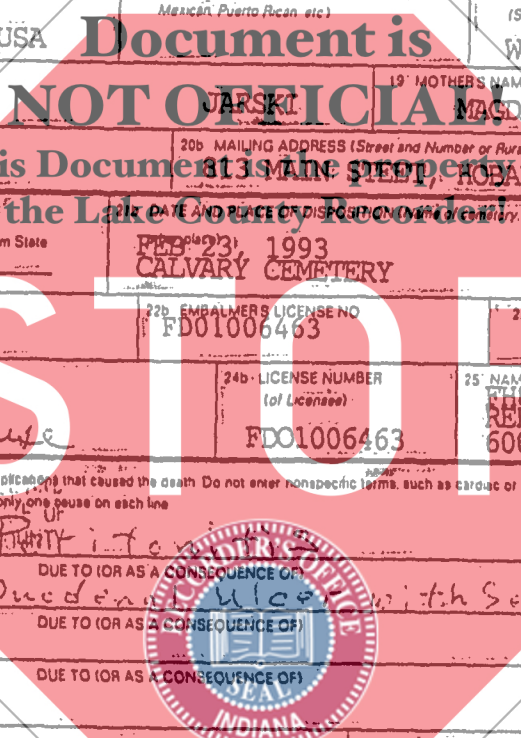
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



FILED

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