

93028984

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2658-92

CERTIFICATE OF DEATH

State No.

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) Edward Andrew Czapala		2 SEX Male	3a TIME OF DEATH 6:33 P.M.	3b DATE OF DEATH (Month Day Yr) December 21, 1992
4 SOCIAL SECURITY NUMBER 312-09-8831	5a AGE--Last Birthday (Years) 74	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo Day, Yr) June 2, 1918
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a WAS DECEDENT A U.S. VETERAN? Yes			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence:			

DECEDENT

9a FACILITY NAME (If not institution, give street and number) Community Hospital	9c CITY, TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake
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10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Sophie Vanco	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Police Officer	12b KIND OF BUSINESS/INDUSTRY City of East Chicago
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13a RESIDENCE--STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 1608 Camellia Drive, Apt. B-1
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13e ZIP CODE 46321	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 DECEASED'S EDUCATION (Specify all highest grade completed) Elementary/Secondary (10-12) College (1, 2 or 3 +)
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PARENTS

18 FATHER'S NAME (First Middle Last) Walter Czapala	19 MOTHER'S NAME (First Middle Maiden Surname) Catherine Kielbasa
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INFORMANT

20a INFORMANT'S NAME (Type/Print) Sophie Czapala	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Camellia Dr., Apt. B-1, Munster, IN 46321	20c Relationship Wife
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DISPOSITION

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) December 24, 1992 Holy Cross Cemetery, Mausoleum	21c LOCATION--City or Town, State Calumet City, Illinois
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CAUSE OF DEATH

22a EMBALMER'S NAME Larry D. Anthony	22b EMBALMER'S LICENSE NO. 01001447	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>	24b LICENSE NUMBER (of Licensee) 01001447	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz F.H. 83002916 9445 Calumet Ave, Munster, IN 46321

CAUSE OF DEATH

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. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MAY 6 1993	Approximate Interval Between Onset and Death 3 months
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5/6/93 Jeff

27. WAS DECEDENT PRESENT AT OR 90 DAYS POST-TESTUM? N/A	28a WAS AN AUTOPSY PERFORMED? No	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) -
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CERTIFIER

29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER DEC 22 1992	To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.	29c MEDICAL LICENSE NO. 01026577	29d DATE SIGNED (Month Day, Year) December 22, 1992
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HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Kwang D. You, M.D. 931 Fran-Lin Pkwy, Munster, IN 46321	31 HEALTH OFFICER'S SIGNATURE WITH COMMISSIONER'S AUTHORITY <i>Alexander S. Williams M.D.</i>	32 DATE FILED (Month Day, Year) December 22, 1992
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CORONER USE ONLY

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined	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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