Local No. 0821-91 93040232

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

5 Rec. 2 Vet. 7 Total

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): MIKE 'MITCH' J. KURZAWINSKI
2 SEX: Male
3a TIME OF DEATH: 6:04A M
3b DATE OF DEATH (Month, Day, Yr): April 15, 1991
4 SOCIAL SECURITY NUMBER: 317-09-2549
5a AGE—Last Birthday (Years): 75
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo, Day, Yr): OCT 4, 1915
7 BIRTHPLACE (City and State or Foreign Country): CHICAGO, ILLINOIS
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1942
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
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): ANNE KOLAK
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MECHANIC-SELF EMPLOYED
12b KIND OF BUSINESS/INDUSTRY: SERVICE STATION
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: HOBART
13d STREET AND NUMBER: 1834 E. 38TH PL.
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): 7; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): FRANK KURZAWINSKI
19 MOTHER'S NAME (First, Middle, Maiden Surname): MARY KASPRZAK

INFORMANT

20a INFORMANT'S NAME (Type/Print): ANNE KURZAWINSKI
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1834 E. 38TH PL., HOBART, IN 46342
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): APR 18, 1991 CALVARY CEMETERY
21c LOCATION—City or Town, State: PORTAGE, INDIANA
22a EMBALMER'S NAME: JAMES W. GHOLSTON
22b EMBALMER'S LICENSE NO.: FDO1004194
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b LICENSE NUMBER (of Licensee): FDO1006463
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. OLD RIDGE RD, HOBART, IN 4634

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)
a. Cardiac failure
DUE TO (OR AS A CONSEQUENCE OF)
b. arteriosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Perforated gastric ulcer
DUE TO (OR AS A CONSEQUENCE OF)
d. Generalized Peritonitis

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 stated in Part I.
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): N/A
28a WAS AN AUTOPSY PERFORMED? (Yes or no):
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

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) and manner 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: R. Almase M.D.
29c MEDICAL LICENSE NO.: 23326
29d DATE SIGNED (Month, Day, Year): 4-16-91
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RODOLFO ALMASE MD, 904 W. RIDGE ROAD, HOBART, IN 46

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.
32 DATE FILED (Month, Day, Year): April 16, 1991

FILED

CORONER USE ONLY

33 MANNER OF DEATH: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
APR 16 1991
LAKE COUNTY HEALTH COMMISSIONER

JUN 22 1993
Oscar N. Antoré
RECORDER LAKE COUNTY
01504

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
JUN 22 1993
RECORDER

17-263-2 Pokagon Heights Unit 4 Lot 10
6/22/93

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT PD 1