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CP 466023 ①

93040762

INDIANA STATE BOARD OF HEALTH

Local No. 3316-91

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>Edward Niksic</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>2:55<sup>AM</sup></b>	3b. DATE OF DEATH (Month, Day, Yr) <b>December 23, 1991</b>
4. SOCIAL SECURITY NUMBER <b>308-28-8053</b>	5a. AGE—Last Birthday (Years) <b>61</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>03-10-30</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>59</b>	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) <b>St. Mary Medical Center</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Hobart</b>	9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Never married</b>	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Truck Driver</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Steel Trans., Inc</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Merrillville</b>	13d. STREET AND NUMBER <b>5860 Massachusetts Street</b>
13e. ZIP CODE <b>46410</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
16. RACE—American Indian, Black, White, etc (Specify) <b>White</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	

PARENTS INFORMANT

18. FATHER'S NAME (First, Middle, Last) <b>Joseph Niksic</b>	19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Manda Niksic</b>
20a. INFORMANT'S NAME (Type/Print) <b>Mary Collins</b>	20b. MAILING ADDRESS (Street, City, State, Zip Code) <b>5860 Massachusetts Street, Merr., IN.</b>
20c. Relationship <b>Sister</b>	

DISPOSITION

21a. METHOD OF DISPOSITION <input checked="" 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) <b>December 27, 1991 Calumet Park Cemetery</b>	21c. LOCATION—City or Town, State <b>Merrillville, IN.</b>
22a. EMBALMER'S NAME <b>David SEMPLINSKI</b>	22b. EMBALMER'S LICENSE NO. <b>FD08600686</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Robert C. Wiatrolak</i>	24b. LICENSE NUMBER (of Licensee) <b>FD01001293</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Stilinovich &amp; Wiatrolak Funeral Home 7535 Taft Street, Merr., IN.</b>

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)  
**Acute respiratory failure**

DU TO (OR AS A CONSEQUENCE OF)  
**Possible unknown embolism**

CONDITIONS, IF ANY, WHICH MAY HAVE CONTRIBUTED TO THE ABOVE OR AS A CONSEQUENCE OF THE ABOVE  
**COMPLETE COPY OF THE AUTOPSY REPORT OF chronic osteoarthritis & Mitral valve regurg disease**

DEATH ON FILE WITH THE HEALTH DEPT.

CERTIFIER

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

**JAN 08 1992**

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>
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HEALTH OFFICER

29a. CERTIFIER (Check only one)  
 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  
*Alexander S. Phillips*

29c. MEDICAL LICENSE NO.  
**01030560**

29d. DATE SIGNED (Month, Day, Year)  
**1/7/92**

CORONER USE ONLY

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)  
**V.R. Garlapati 61st & Harrison Street Merrillville, IN. 46410**

31. HEALTH OFFICER'S SIGNATURE  
*Alexander S. Phillips*

32. DATE FILED (Month, Day, Year)  
**January 8, 1992**

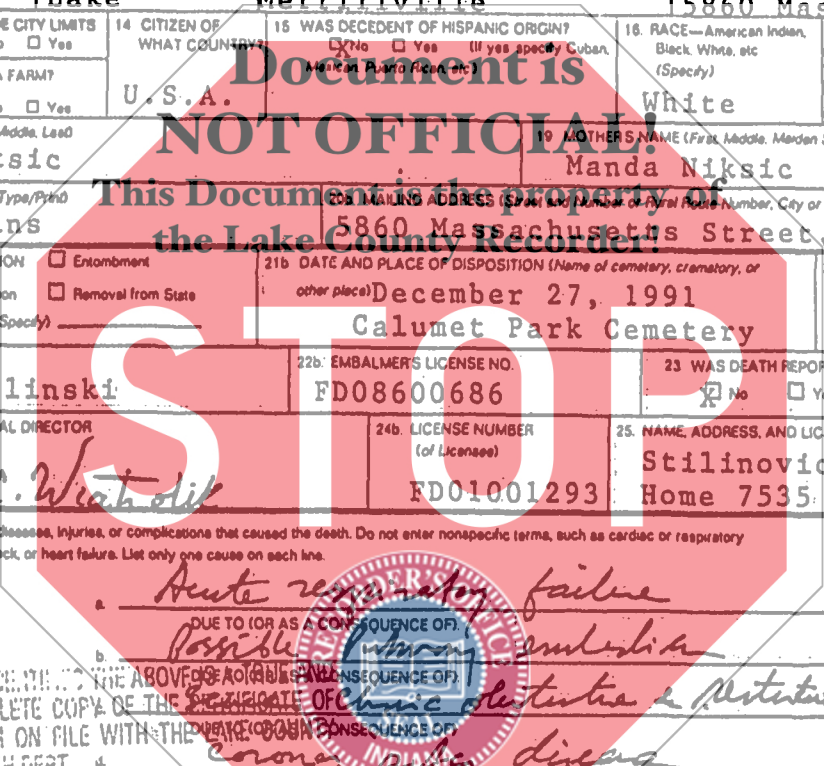
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34e. DESCRIBE HOW INJURY OCCURRED
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34g. DATE PRONOUNCED DEAD (Month, Day, Year)

34h. MOTOR VEHICLE ACCIDENT? (Yes or no)  
**NO**

**AUDITOR LAKE COUNTY** **01584**

LT 35 & N 12 1/2 FT BK 4, LT 36, BK 4, PB 20/59, GROSS PARK ADD



Chicago Title Insurance Company

STATE OF INDIANA DEPT. OF HEALTH

FILED JUN 23 1993