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# PORTER COUNTY BOARD OF HEALTH
# 93041474 MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First Middle Last): Joseph A. Dumbsky
2 SEX: Male
3a TIME OF DEATH: 2:10 A M
3b DATE OF DEATH (Month Day Yr): June 19, 1993
4 SOCIAL SECURITY NUMBER: 304-09-3955
5a AGE—Last Birthday (Years): 90
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): January 26, 1903
7 BIRTHPLACE (City and State or Foreign Country): Illinois
8a WAS DECEDENT A U S VETERAN?: No
8b YEAR LAST SERVED IN U S ARMED FORCES?:
9a PLACE OF DEATH (Check only one See instructions): ☐ HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☒ OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution give street and number): Canterbury Place
9c CITY TOWN OR LOCATION OF DEATH: Valparaiso
9d COUNTY OF DEATH: Porter
10 MARITAL STATUS (Specify): Never Married
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): Carpenter
12b KIND OF BUSINESS/INDUSTRY: Local Union
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Dyer
13d STREET AND NUMBER: 210 Berens St.
13e ZIP CODE: 46311
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 8 College (1-4 or 5 +):

**PARENTS**

18 FATHER'S NAME (First Middle Last): John Dumbsky
19 MOTHER'S NAME (First Middle Maiden Surname): Margaret Neislus

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Hubert N. Dumbsky
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 210 Berens St. Dyer, Indiana 46311
20c Relationship: Nephew

**DISPOSITION**

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): June 22, 1993 St Joseph Cemetery
21c LOCATION—City or Town State: Dyer, Indiana
22a EMBALMER'S NAME: Edward F. Mullaney
22b EMBALMER'S LICENSE NO: FDO 1007176
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Edward F. Mullaney
24b LICENSE NUMBER (of Licensee): FDO 1007176
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Fagen-Miller Funeral Gardens Inc 1920 Hart St. Dyer, Indiana 46311 FH83001504

**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): a Cardiorespiratory Failure
DUE TO (OR AS A CONSEQUENCE OF): b Ischemic Cardiomyopathy
Conditions if any, which gave rise to the immediate cause stating the underlying cause last: c
DUE TO (OR AS A CONSEQUENCE OF): d

Approximate Interval Between Onset and Death: 42 Hrs Minutes Days

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): No
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

**CERTIFIER**

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: Kalra
29c MEDICAL LICENSE NO: 0103 7891
29d DATE SIGNED (Month Day Year): June 22, 1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. NAZIAZI M.D 404 10TH STREET DEMOTTE IN 46310

**HEALTH OFFICER**

31 HEALTH OFFICER'S SIGNATURE: Gary A. Babcock, MD
32 DATE FILED (Month Day Year): June 22, 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
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

FILED JUN 28 1993 AUDITOR LAKE COUNTY

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