

93046881

4301 Magoun Ave.  
East Chic, IN 46512  
Helen Pramuk.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2487-92

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>ARTHUR J. PRAMUK</b>				2. SEX <b>MALE</b>	3a. TIME OF DEATH <b>3:58 A.M.</b>	3b. DATE OF DEATH (Month, Day, Year) <b>NOVEMBER 28, 1992</b>
4. SOCIAL SECURITY NUMBER <b>313-01-6619</b>	5a. AGE—Last Birthday (Years) <b>74</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Sept. 9, 1918</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Whiting, Indiana</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>	HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		9a. PLACE OF DEATH (Check only one. See instructions) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		

DECEDENT

9b. FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>		9d. COUNTY OF DEATH <b>LAKE</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Helen A. Savage</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Research Technician</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Amoco Oil Company</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>East Chicago</b>	13d. STREET AND NUMBER <b>4301 Magoun Avenue</b>		

PARENTS

13e. ZIP CODE <b>46312</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	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+): <b>-</b>	
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INFORMANT

18. FATHER'S NAME (First, Middle, Last) <b>Michael Pramuk</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Veronica Miklosy</b>	
20a. INFORMANT'S NAME (Type/Print) <b>Helen A. Pramuk</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4301 Magoun Ave., E. Chgo., IN 46312</b>	
20c. Relationship <b>Wife</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 1, 1992 Elmwood Cemetery</b>	21c. LOCATION—City or Town, State <b>Hammond, Indiana</b>
22a. EMBALMERS NAME <b>Woodrow W. Donovan</b>	22b. EMBALMER'S LICENSE NO. <b>FD01053135</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes

CAUSE OF DEATH

24a. SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lipe</i>	24b. LICENSE NUMBER (of Licensee) <b>FD01020366</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>FIFE FUNERAL HOME FH85001512 4201 Indpls. Blvd., E. Chgo., IND.</b>
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. <b>coronary artery disease</b> <b>congestive heart failure</b> <b>ventricular tachycardia</b>		26. PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>chronic obstructive pulmonary disease</b>

CERTIFIER

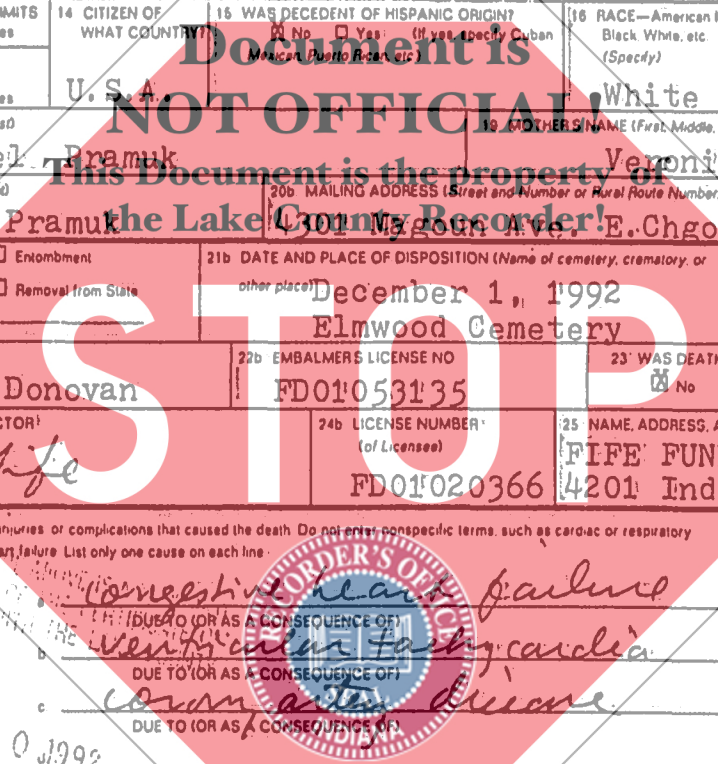
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	28b. VERBAL FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN 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>[Signature]</i> <b>AUDITOR LAKE COUNTY</b>
29c. MEDICAL LICENSE NO. <b>31576</b>		29d. DATE SIGNED (Month, Day, Year) <b>NOVEMBER 29, 1992</b>

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DR. WON-SHICK LOH, M. D., 9134 COLUMBIA AVENUE, MUNSTER, INDIANA 46321</b>	
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>	32. DATE FILED (Month, Day, Year) <b>November 30, 1992</b>

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"/> Could not be Determined <input type="checkbox"/> 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) <b>00839</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		



STATE OF INDIANA  
CORONER  
LAKE COUNTY  
NOV 30 09 PM '92  
FILED