K-Y - 33-17-35

GRAND KRAY
8721 KENNEDY
HIGHLAND

93088178

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 807

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Oct 1 1993
State Date Issued

Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): AUGUST JURES
2. SEX: MALE
3a. TIME OF DEATH: 5:30 AM
3b. DATE OF DEATH (Mon. Day, Yr.): OCTOBER 1, 1993
4. SOCIAL SECURITY NUMBER: 312-10-8636
5a. AGE—Last Birthday (Years): 82
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): AUG. 28, 1911
7. BIRTHPLACE (City and State or Foreign Country): COLFAX, IOWA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
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): 3812 JOHNSON AVENUE
9c. CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): HELEN KRAJEWSKI
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HAMMERSMITH
12b. KIND OF BUSINESS/INDUSTRY: FORGE COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 3812 JOHNSON AVENUE
13e. ZIP CODE: 46327
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): GREGORY JURCICH
19. MOTHER'S NAME (First, Middle, Maiden Surname): SOPHIE SEKMAR

INFORMANT

20a. INFORMANT'S NAME (Type/Print): HELEN JURES
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3812 JOHNSON, HAMMOND, INDIANA 46327
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): OCTOBER 4, 1993 HOLY CROSS CEMETERY
21c. LOCATION—City or Town, State: CALUMET CITY, ILLINOIS
22a. EMBALMER'S NAME: KEITH D. ANTHONY
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOSZ FUNERAL HOME, FH 83002855, 4404 CAMERON, HAMMOND, IN 46327

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. Severe Pulmonary Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Myocardial Infarct
DUE TO (OR AS A CONSEQUENCE OF):
c. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
d. Original Brain Syndrome

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:

Approximate Interval Between Onset and Death:

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

27. WAS DECEDENT PREGNANT OR 60 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): 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.
AUDITOR LAKE COUNTY
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. MEDICAL LICENSE NO.: 02001336
29d. DATE SIGNED (Month, Day, Year): OCTOBER 1, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): D. STORK M.D. 7905 CALUMET AVENUE, MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): October 1 1993

33. MANNER OF DEATH: ☒ 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.

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