94002875

INDIANA STATE DEPARTMENT OF HEALTH

Local No. T048-93

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
WILLIAM SAKO Jr.	MALE	6:13 P M	MAY 13, 1993

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr)	7. BIRTHPLACE (City and State or Foreign Country)
306-01-5341	75			MARCH 28, 1918	EAST CHICAGO, INDIANA

8a. WAS DECEDENT A US VETERAN?	8b. YEAR LAST SERVED IN US ARMED FORCES?	9a. PLACE OF DEATH (Check only one See instructions)
YES	1945	HOSPITAL ☐ Inpatient ☒ ER Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
MARRIED	GENEVIEVE MONDRZAK	INSPECTOR	RAILROAD

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	HIGHLAND	8618 PARRISH

13e. ZIP CODE	13f. INSIDE CITY LIMITS	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16. RACE—American Indian Black White etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)
46322	☐ No ☒ Yes; 13g. ON A FARM? ☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last)	19. MOTHER'S NAME (First Middle Maiden Surname)
WILLIAM SAKO	MARY VOZAR

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c. Relationship
GENEVIEVE SAKO	8618 PARRISH HIGHLAND, IN 46322	WIFE

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c. LOCATION—City or Town State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	MAY 17, 1993 CALUMET PARK CEMETERY	MERRILLVILLE, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
LEONARD GREGORCZYK	FD08800305	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01006015	FAGEN-MILLER FUNERAL GARDENS, INC. 2828 HIGHWAY AVE. HIGHLAND, IN FH83003035

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

CAUSE OF DEATH

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

a. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Acute Myocardial Infarction
b. DUE TO (OR AS A CONSEQUENCE OF)	Coronary Atherosclerosis
c. DUE TO (OR AS A CONSEQUENCE OF)	
d. DUE TO (OR AS A CONSEQUENCE OF)	

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

MAY 14 1993

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

FILED

LAKE COUNTY HEALTH DEPARTMENT

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
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) and manner 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
[signature] MD	018511	5/14/93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ERNEST C. MIRICH-MD 9001 BROADWAY MERRILLVILLE IND 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
[signature] M.D	May 14, 1993

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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

SDH06 004 State Form 10110 (R3 / 3-92) DEATHCER PD 1 → John Halcarz 9013 Indpls Blvd Highland In 46322