Danko v Goldsmith
P.O. Box 510
Whiting 46394

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 591-92 94018817 State No. 91

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): EVELYN F. LEWANDOWSKI
2. SEX: FEMALE
3a. TIME OF DEATH: 8:18 PM
3b. DATE OF DEATH (Month, Day, Yr.): JULY 26, 1992
4. SOCIAL SECURITY NUMBER: 317-32-5614
5a. AGE—Last Birthday (Years): 59
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): Oct. 28, 1932
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: no
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: none
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): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Edwin Lewandowski
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Co-Owner
12b. KIND OF BUSINESS/INDUSTRY: "Old Glory" Tavern
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 6755 Indianapolis Blvd.
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): Stanley Zych
19. MOTHER'S NAME (First, Middle, Maiden Surname): Stella Krolikowski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mr. Edwin Lewandowski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6755 Indianapolis Blvd. Hammond, IN 46324
20c. Relationship: Husband

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): July 29, 1992 Park Crematory
21c. LOCATION—City or Town, State: Park Forest, Illinois
22a. EMBALMER'S NAME: none
22b. EMBALMER'S LICENSE NO.: none
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John P. Stutt
24b. LICENSE NUMBER (of Licensee): FD01013507
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. [illegible]

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

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

I CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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.

JUL 27 1992

29b. SIGNATURE AND TITLE OF CERTIFIER: Salman D. Gailani
29c. MEDICAL LICENSE NO.: 27970
29d. DATE SIGNED (Month, Day, Year): JULY 27, 1992

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SALMAN D. GAILANI MD, 9146 COLUMBIA AVENUE MUNSTER, INDIANA 46321
31. HEALTH OFFICER'S SIGNATURE: LAKE COUNTY HEALTH COMMISSIONER Alexander Williams, M.D.
32. DATE FILED (Month, Day, Year):

CORONER USE ONLY

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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SDH06-004 State Form 10110 (R/1-92) DEATHCER/PD 1

Key # 33-114-30 & 31 L.30 Bl. 1 L.31 Bl. 1 Forsythe Highland Rd.