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ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Rustic Acres Lot 23
Key # 7-274-23

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0420-94 94G13042 **CERTIFICATE OF DEATH** State No. un.1 #03

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	Basil Herbach
2 SEX	Male
3a TIME OF DEATH	9:56P M
3b DATE OF DEATH (Month Day Yr)	February 13, 1994
4 *SOCIAL SECURITY NUMBER	316-09-3177
5a AGE—Last Birthday (Years)	73
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo. Day Yr)	Jan. 20, 1921
7 BIRTHPLACE (City and State or Foreign Country)	Homestead, PA.
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1945
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	Methodist Hospital-Southlake
9c CITY, TOWN OR LOCATION OF DEATH	Merrillville
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Violet Dimitroff
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Guild Repair Merchant
12b KIND OF BUSINESS/INDUSTRY	U.S. Steel
13a RESIDENCE—STATE	IN.
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Crown Point
13d STREET AND NUMBER	888 E. 135th Street
13e ZIP CODE	46307
13f INSIDE CITY LIMITS	[ ] No [X] Yes
13g ON A FARM?	[X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Peter Gorbacheff
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Theodosia N/A

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Violet Herbach
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	888 E. 135th Crown Point, IN. 46307
20c Relationship	Wife

tax mailing address

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	02-17-94 Calumet Park Cemetery
21c LOCATION—City or Town, State	Merrillville, IN.
22a EMBALMER'S NAME	David Semplinski
22b EMBALMER'S LICENSE NO	FD08600686
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Robert Wiatrolik (signature)
24b LICENSE NUMBER (of Licensee)	FD01001293
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH3004455 Stilinovich & Wiatrolik 7535 Taft St. Merrillville, IN.

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. Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):
b. Atrial Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
c. ? Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

FEB 17 1994

FILED MAR 14 1994

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

Field	Entry
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?	No

CERTIFIER

29a CERTIFIER (Check only one)
- [X] 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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	(signature)
29c MEDICAL LICENSE NO	01032180
29d DATE SIGNED (Month, Day, Year)	2/16/94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. S. Shah 5825 Broadway Suite A Merrillville, IN. 46410 769-9020

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD
32 DATE FILED (Month, Day, Year)	February 17, 1994

Field	Entry
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 (R4/3-93) Deathcer/PD 1

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