94024776

SUITE F
8300 Mississippi
Merr., IN. 46410
Janu [illegible]

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0522-93 — State No. ....

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)	FRANK DELNIKS
2 SEX	MALE
3a TIME OF DEATH	8:50 P.M.
3b DATE OF DEATH (Month Day Yr)	MARCH 9, 1993
4 SOCIAL SECURITY NUMBER	304-42-7208
5a AGE—Last Birthday (Years)	97
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	Oct. 5,1895
7 BIRTHPLACE (City and State or Foreign Country)	Medicine Hat Alberta Canada
8a WAS DECEDENT A US VETERAN?	no
8b YEAR LAST SERVED IN US 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)	single
11 SURVIVING SPOUSE (If wife, give maiden name)	none
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Embalmer
12b KIND OF BUSINESS/INDUSTRY	Funeral Home
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	E.Chicago
13d STREET AND NUMBER	3828 Pulaski St.
13e ZIP CODE	46312
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Joseph Delniks
19 MOTHER'S NAME (First Middle Maiden Surname)	Petronella Jakztys

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Eleanore LaBaw
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	11 Heather Ln. Greenwich Ct. 06838
20c Relationship	friend

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☐ Burial ☐ Cremation ☐ Donation ☒ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	March13,1993 Calumet Park Cemetery
21c LOCATION—City or Town, State	Merrillville IN.
22a EMBALMER'S NAME	Eric Prusiecki
22b EMBALMER'S LICENSE NO	FD01022431
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Eric Prusiecki (signature)
24b LICENSE NUMBER (of Licensee)	FD01022431
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Prusiecki Funeral Home Inc. P.O.Box J E.Chicago, IN. 46312 FDH3001562

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

THIS CERTIFIES COMPLETE DEATH ON FILE WITH THE [illegible] HEALTH DEPT.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Cardio-Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF)

b. Generalized arterio-sclerosis

MAR 1 1993

DUE TO (OR AS A CONSEQUENCE OF)

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

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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

1. Pneumonia & dehydration
2. Generalized debility
3. ... [illegible]

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? (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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	(signature)
29c MEDICAL LICENSE NO	21655
29d DATE SIGNED (Month, Day, Year)	MARCH 10, 1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DR. FELICIANO F. JIMENEZ, M. D. 800 MACARTHUR BLVD. MUNSTER, INDIANA 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	(signature) MD
32 DATE FILED (Month, Day, Year)	March 12, 1993

CORONER USE ONLY

FILED

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	

APR 4 1993

(signature) AUDITOR LAKE COUNTY

90[illegible]

2nd Add. Ind. Harbor ALL L.21 BL.14 Key# 30-346-20

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1