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94026660

PORTER COUNTY BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): FRANCIS JOHN CERJESKI
2. SEX: Male
3. TIME OF DEATH: 5:35 P
4. DATE OF DEATH (Month Day Yr): July 27, 1993
5. SOCIAL SECURITY NUMBER: 312-05-5982
6a. AGE—Last Birthday (Years): 74
6b. UNDER 1 YEAR (Months Days):
6c. UNDER 1 DAY (Hours Minutes):
7. DATE OF BIRTH (Mo Day Yr): October 8, 1918
8. BIRTHPLACE (City and State or Foreign Country): Whiting, Indiana
8a. WAS DECEDENT A US VETERAN?: No
8b. YEAR LAST SERVED IN US ARMED FORCES?: ---
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): Miller's Merry Manor
9c. CITY TOWN OR LOCATION OF DEATH: Portage
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Mary Polomchak
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Battalion Chief
12b. KIND OF BUSINESS/INDUSTRY: Gary Fire Department
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 516 Miami Street
13e. ZIP CODE: 46403
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? (Mexican, Puerto Rican, etc): ☒ No ☐ Yes (If yes specify Cuban)
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): Walter Cerjeski
19. MOTHER'S NAME (First Middle Maiden Surname): Gertrude Petzel

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary Cerjeski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 516 Miami Street, Gary, Indiana 46403
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): July 30, 1993 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO: 1042372
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1009893
24c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

CAUSE OF DEATH

25. 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. Cardiac arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
b. Dehydration and electrolyte imbalance
DUE TO (OR AS A CONSEQUENCE OF):
c. Granulomatosis colitis
DUE TO (OR AS A CONSEQUENCE OF):
d.

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: Senile dementia - cerebral arteriosclerosis

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

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. MEDICAL LICENSE NO: 17667
29d. DATE SIGNED (Month Day Year): July 28, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (Type/Print): Dr. Barton, 6101 Miller Avenue, Gary, Indiana 46409

HEALTH OFFICER

31. HEALTH OFFICER SIGNATURE: [signature] M.D.
32. DATE FILED (Month Day Year): July 28, 1993

FILED APR 8 1994

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:
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: Donna M. Barton [illegible] 00495

Gary Black 2nd Sub. L.13 BL.B
Ne'lif 20FT of L 14 BL.B
Sw'ly 30FT of Key # 43-52-14

No. 608177

PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

Gary A. Babcock, MD
HEALTH OFFICER