

184160

STATE OF INDIANA
LAKE COUNTY

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INDIANA STATE DEPARTMENT OF HEALTH

Local No. **94091599**

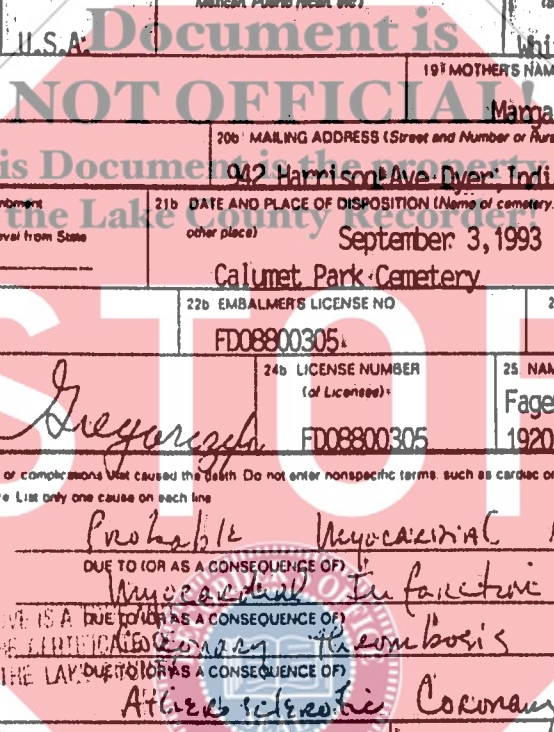
CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
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1 DECEASED—NAME (First Middle Last) MICHAEL JEFFREY SAMUEL ORLICH RECORDER		2 SEX MALE	3a TIME OF DEATH 7:15 A.M.	3b DATE OF DEATH (Month Day Year) SEPTEMBER 1, 1993	
4 SOCIAL SECURITY NUMBER 352-36-2201	5a AGE—Last Birthday (Years) 48	5b UNDER 1 YEAR Months: Days	5c UNDER 1 DAY Hours: Minutes	6 DATE OF BIRTH (Mo Day Yr) June 22, 1945	
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana	8a WAS DECEDENT A U.S. VETERAN? No				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> IDOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence <input type="checkbox"/>			
9a FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9b CITY TOWN OR LOCATION OF DEATH MUNSTER	9c COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Paula Orsini	12a DECEDENT'S USUAL OCCUPATION (Give kind of work. Job done during most of working life. Do not use retired) Scale Technician		12b KIND OF BUSINESS/INDUSTRY Self-Employed	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Dyer	13d STREET AND NUMBER 942 Harrison Ave		
13e ZIP CODE 46311	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (1-12) 12 College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) John Masnick			
19 MOTHER'S NAME (First Middle Maiden Surname) Margaret Wiening		20a INFORMANT'S NAME (Type/Print) Paula Masnick			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 942 Harrison Ave, Dyer, Indiana 46311		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) September 3, 1993 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Leonard Gregorczyk		22b EMBALMER'S LICENSE NO. FD08800305	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Leonard Gregorczyk</i>		24b LICENSE NUMBER (of Licensee) FD08800305	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens, INC 1920 Hart Street, Dyer, IN 46311 FH83001504		
26 PART I: Enter the disease, 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)		Probable Myocardial Rupture		Approximate Interval Between Onset and Death minutes	
DUE TO (OR AS A CONSEQUENCE OF)		Myocardial Infarction		days	
DUE TO (OR AS A CONSEQUENCE OF)		Coronary Thrombosis		days	
DUE TO (OR AS A CONSEQUENCE OF)		Atherosclerotic Coronary Artery Disease		years	
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I Diabetes Mellitus, Hypertensive, Excessive Obesity, Coronary Artery Disease					
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)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>C.R. Smith, M.D.</i>			
29c. MEDICAL LICENSE NO. 00747		29d. DATE SIGNED (Month Day, Year) SEPTEMBER 1, 1993			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. C. RICHARD SMITH, D. O. 761 45TH STREET MUNSTER, INDIANA 46321					
31. HEALTH OFFICER'S SIGNATURE <i>C. Richard Smith, M.D.</i>				32. DATE FILED (Month Day, Year) September 3, 1993	
33. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			



ICE PARENTS INFORMANT DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Lat 340 Northgate 5th addition to house 1100 E 34th Rd, Dyer, Indiana 46311

600 BK