Army Surp. 35B
1001 Main St
Dyer, In 46311

472609

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE INDIANA STATE HEALTH DEPARTMENT.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
94 APR 27 PM 1:19
SAMUEL ORLICH
RECORDER

Local No. 693

Date Issued: [illegible] Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last): Francis J. Bajza	2 SEX: Male	3a TIME OF DEATH:	3b DATE OF DEATH (Month, Day, Yr.): August 16, 1993		
4 SOCIAL SECURITY NUMBER: 317-32-7278	5a AGE—Last Birthday (Years): 60	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo., Day, Yr.): Jan. 29, 1933	7 PLACE OF BIRTH (City and State or Foreign Country): East Chicago, Indiana
8a WAS DECEDENT A U.S. VETERAN?: Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1973	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA	OTHER [ ] Nursing Home [X] Other (Specify) [ ] Residence		

DECEDENT

9b FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Hospital	9c CITY, TOWN OR LOCATION OF DEATH: Hammond	9d COUNTY OF DEATH: Lake	
10 MARITAL STATUS (Specify): Divorced	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): Soldier	12b KIND OF BUSINESS/INDUSTRY: United States Army
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Hammond	13d STREET AND NUMBER: 4930 Ash Avenue

13e ZIP CODE: 46327	13f INSIDE CITY LIMITS? [ ] No [X] Yes	13g ON A FARM? [X] No [ ] Yes	14 CITIZEN OF WHAT COUNTRY: USA	15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): John Francis Bajza	19 MOTHER'S NAME (First, Middle, Maiden Surname): Bernice Kozdras

INFORMANT

20a INFORMANT'S NAME (Type/Print): Joseph J. Bajza	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 119 Eagle Street, Gypsum, Colorado 81736	20c Relationship: Son

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Entombment [ ] Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 20, 1993 Holy Cross Cemetery	21c LOCATION—City or Town, State: Calumet City, Illinois
22a EMBALMER'S NAME: Keith D. Anthony	22b EMBALMER'S LICENSE NO: 0101191	23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony	24b LICENSE NUMBER (of Licensee): 01011911	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Anthony & Dziadowicz FH 83002835, 4404 Cameron, Hammond, In 46327

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. HEPATO-RENAL FAILure		DAYS
DUE TO (OR AS A CONSEQUENCE OF): b. GASTRO INTESTINAL hemorrhage	(1)	DAYS
DUE TO (OR AS A CONSEQUENCE OF): c. ESOPHAGEAL VARICES	(2)	DAYS
DUE TO (OR AS A CONSEQUENCE OF): d. ALCOHOLism	(3)	YEARS

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

APR 26 1994

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

	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

Anna N. Anton
AUDITOR LAKE COUNTY

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.

29b SIGNATURE AND TITLE OF CERTIFIER: Alan Jones M.D.	29c MEDICAL LICENSE NO: 640	29d DATE SIGNED (Month, Day, Year): August 18, 1993

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Alan Jones, 9128 Columbia Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Fremuth M.D.	32. DATE FILED (Month, Day, Year): August 19, 1993

CORONER USE ONLY

33 MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide	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 (R3 / 3-92) DEATHCER/PD 1