STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 94032086 .... 94 APR 28 AM 11 00

CERTIFICATE OF DEATH

State No. ....

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

SAMUEL ORLICH
RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Dr. Joseph M. Pavlik
2 SEX: Male
3a TIME OF DEATH: 8:56 p.m.
3b DATE OF DEATH (Month Day Yr): October 16, 1993
4 SOCIAL SECURITY NUMBER: 313-34-2918
5a AGE—Last Birthday (Years): 62
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): July 22, 1931
7 BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a WAS DECEDENT A U.S. VETERAN? Yes
8b YEAR LAST SERVED IN US ARMED FORCES? 1962
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): 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): Patricia
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Dentist
12b KIND OF BUSINESS/INDUSTRY: Self
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Crown Point
13d STREET AND NUMBER: 622 W. 94th Court
13e ZIP CODE: 46307
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? ☒ 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+): +4

PARENTS

18 FATHER'S NAME (First Middle Last): Michael J. Pavlik
19 MOTHER'S NAME (First Middle Maiden Surname): Clara P. Janosik

INFORMANT

20a INFORMANT'S NAME (Type/Print): Patricia Pavlik
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 622 W. 94th Ct. Crown Point, IN. 46307
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 20, 1993 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: David Semplinski
22b EMBALMER'S LICENSE: FD08600686
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD01001293
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Stillinovich & Wiatrolik FH30044455 7535 Taft Merrillville, IN. 46410

FILED APR 28 1994 [signature] AUDITOR LAKE COUNTY

23-163-025

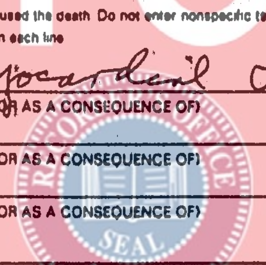
CAUSE OF DEATH

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	Myocardial Infarction	Acute
DUE TO (OR AS A CONSEQUENCE OF) b		
DUE TO (OR AS A CONSEQUENCE OF) c		
DUE TO (OR AS A CONSEQUENCE OF) d		

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

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



THIS IS TO CERTIFY THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY

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.

29b SIGNATURE AND TITLE OF CERTIFIER: X Raymond J. Doherty
29c MEDICAL LICENSE NO: 01016733
29d DATE SIGNED (Month Day, Year): 10-18-93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Doherty 8695 Connecticut Merrillville, IN. 46410 769-6363

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32 DATE FILED (Month Day, Year): October 19, 1993

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.

200

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

6.00

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