ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Patricia Wiatrolik

# INDIANA STATE DEPARTMENT OF HEALTH

Local No. 94-0501

## CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED—NAME (First, Middle, Last): SAM ROBERT MATIJEVICH
2. SEX: Male
3a. TIME OF DEATH: 4:45A M
3b. DATE OF DEATH (Month, Day, Yr.): June 30, 1994
4. SOCIAL SECURITY NUMBER: 304-34-4523
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day Yr.): FEB. 14, 1918
7. BIRTHPLACE (City and State or Foreign Country): Gary, IN.
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? n/a
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): 839 E. Ridge Rd
9c. CITY, TOWN OR LOCATION OF DEATH: Gary
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): Maintenence
12b. KIND OF BUSINESS/INDUSTRY: Gary Screw & Bolt
13a. RESIDENCE—STATE: IN.
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 839 E. Ridge Rd.
13e. ZIP CODE: 46408
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+):

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): Vincent Matijevich
19. MOTHER'S NAME (First, Middle, Maiden, Surname): Anna Bukovec

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Bonnie Gambel
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 839 E. Ridge Rd. Gary, IN 46408
20c. RELATIONSHIP: Sister

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, other place): July 2, 1994 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, IN.
22a. EMBALMER'S NAME: David Semplinski
22b. EMBALMER'S LICENSE NO.: FD08600686
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes

**CERTIFIER**

24a. SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b. LICENSE NUMBER (of Licensee): FD01001293
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Stilinovich & Wiatrolik 7535 Taft St. Merrillville, IN 46410 FH3004455

**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. HYPOTENSION
DUE TO (OR AS A CONSEQUENCE OF):
b. METASTATIC CANCER OF THE LIVER
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

27. WAS DECEDENT PREGNANT/POSTPARTUM? (Yes or no): No
28a. IF FEMALE, WAS DECEDENT PREGNANT WITHIN LAST YEAR? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

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) 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) as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Vyas MD
29c. MEDICAL LICENSE NO.: 03692
29d. DATE SIGNED (Month, Day, Year): 7/8/94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Vyas 3229 Broadway Gary, IN 980-7178

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): JUL 21 1994

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.

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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
95 JAN -3 AM 9:28

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1