FA14071 ①

Local No. 793

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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

MAY 3 1993 Date Issued — [signature] Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Walter W. Bolek
2. SEX: Male
3a. TIME OF DEATH: 1:20A M
3b. DATE OF DEATH (Month, Day, Yr.): September 12, 1992
4. SOCIAL SECURITY NUMBER: 309 09 1350
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): July 15, 1915
7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
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): St. Margaret Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Emily Klapsa
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machinist
12b. KIND OF BUSINESS/INDUSTRY: Manufacturing Industry
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Cook
13c. CITY, TOWN, OR LOCATION: Calumet City
13d. STREET AND NUMBER: 657 Freeland
13e. ZIP CODE: 60409
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+): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): Vincent Bolek
19. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Tarabula

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Emily Bolek
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 657 Freeland Calumet City, Illinois 60409
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☒ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 15, 1992 Holy Cross Mausoleum
21c. LOCATION—City or Town, State: Calumet City, Illinois
22a. EMBALMER'S NAME: Leo V. Hennessy
22b. EMBALMER'S LICENSE NO: IL 034-010388
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1013612
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: McCoy F.H. 5713 Hohman Hammond IN 287 for NOWAK FUNERAL HOME CALUMET CITY IL

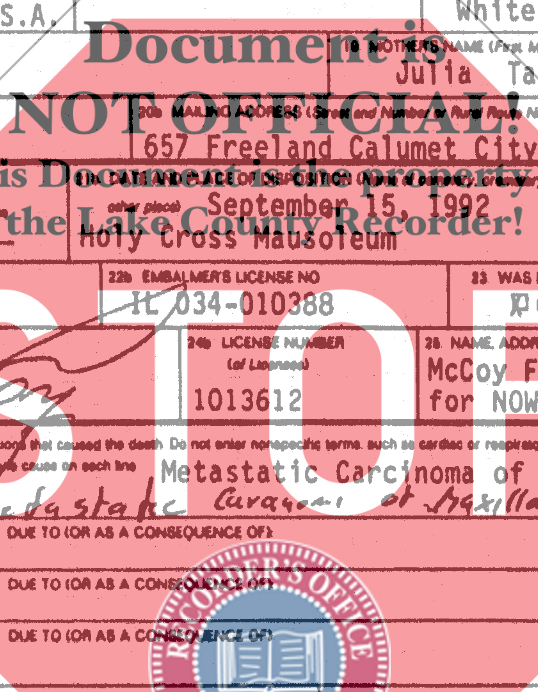
CAUSE OF DEATH

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Metastatic Carcinoma of Maxillary Sinus — *Metastatic Carcinoma of Maxillary Sinus* — Approximate Interval Between Onset and Death: *Months*
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: Hypercalceral Fibrocystic disease of chest and lungs — *Hypercalcemia; Fibrocystic disease of chest and lungs*
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): N/A



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STOP
RECORDER'S OFFICE SEAL INDIANA

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]
29c. MEDICAL LICENSE NO.: 27640
29d. DATE SIGNED (Month, Day, Year): September 12, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. L. Bernstein 5500 Hohman Avenue Suite 1-D Hammond IN 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32. DATE FILED (Month, Day, Year): September 14, 1992

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? (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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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO 1

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95 JAN ... AM 9:49
AMASA G. COLBY CHIEF DEP. RECORDER LAKE CO. STATE OF INDIANA