

34-58-25

S. 34 FT L14

BL8 HARTMAN'S GARDEN'S 2ND ADD

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

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3215-94

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 10-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

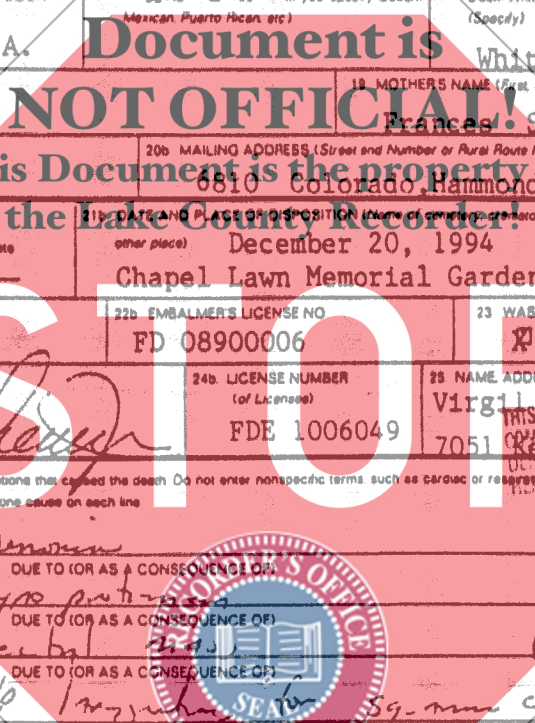
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Joseph John Gurnak		2 SEX male	3a TIME OF DEATH 8:15 a.m.	3b DATE OF DEATH (Month Day Year) December 17, 1994
4 *SOCIAL SECURITY NUMBER 305-20-0112		5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr) June 11, 1921		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? 1945	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) Munster-Med Inn		9c CITY TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Pauline Gurnak	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Lineman	12b KIND OF BUSINESS/INDUSTRY Electrical	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond	13d STREET AND NUMBER 6810 Colorado	
13e ZIP CODE 46323	14 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14a 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 (0-12) <input type="checkbox"/> College (1-4 or 5+) 12 2		18 FATHER'S NAME (First Middle Last) George Gurnak		
19 MOTHER'S NAME (First Middle Maiden Surname) Frances Suknaroski		20a INFORMANT'S NAME (Type/Print) Pauline Gurnak		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Colorado, Hammond, IN, 46323		20c Relationship to Decedent Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input 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) December 20, 1994 Chapel Lawn Memorial Garden		21c LOCATION—City or Town, State Scherverville, Indiana	
22a EMBALMER'S NAME George J. Johnson		22b EMBALMER'S LICENSE NO. FD 08900006	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of License) FDE 1006049	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home 3602869 7051 Kennedy Ave. Hammond, IN, 46323	
26 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory failure. Approximate interval between onset and death. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Pneumonia</i> b. <i>Hypertension</i> c. <i>MI</i> d. <i>SP</i> CONDITIONS: if any which gave rise to the immediate cause stating the underlying cause last: <i>Multiple diseases of D. & S. system resulting in renal insufficiency</i>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <i>Yes</i>		
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <i>Yes</i>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CERTIFICATE OF DEATH? (Yes or no)		
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN <input checked="" type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		
29c. MEDICAL LICENSE NO. 02001336		29d. DATE SIGNED (Month Day Year) 12/19/94		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) FILED 7907 Calumet Avenue, Munster, IN 46321				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams, M.D.</i>		32 DATE FILED (Month Day Year) December 20, 1994		
33a. DATE OF INJURY (Month Day Year) 12/12/1994		33b. TIME OF INJURY	33c. INJURY AT WORK? (Yes or no)	33d. DESCRIBE HOW INJURY OCCURRED
34a. 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.		



STATE OF INDIANA
 LAKE COUNTY
 HEALTH DEPARTMENT
 RECEIVED
 DEC 20 1994
 AMASA G. COBB
 CHIEF DEPT. REC'D

AUDITOR LAKE COUNTY

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