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

JAN 26 1995
Date Issued

Hammond Health Commissioner

Local No. 378

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Mo. Day Yr.)
DONALD	W.	GIBA	Male	April 27, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
317-38-4552	49			OCT. 16, 1938	HAMMOND, INDIANA

8 YEAR LAST SERVED IN U.S. ARMED FORCES? 1964

9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARGARET HOSPITAL	HAMMOND	LAKE

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	RITA J. ROGUS	SERVICEMAN	TOWN OF HIGHLAND PUBLIC WORKS DEPT.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HIGHLAND	2137 41st PLACE

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] No [ ] Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	NO	46322	XX	WHITE		2

PARENTS

17 FATHER'S NAME (First, Middle, Last): WALTER S. GIBA

18 MOTHER'S NAME (First, Middle, Maiden Surname): HARRIET RADZIWILCKI

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
RITA GIBA	2137 41st PLACE HIGHLAND, IND. 46322	WIFE

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION—City or Town, State
XX Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	APRIL 29, 1988 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	21c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Lawrence Miller	FDE1006015	FAGEN-MILLER FUNERAL GARDENS, INC. HIGHLAND, IND. 46322 FDH3003035

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <

23b LICENSE NUMBER

23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month/Day/Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
3:40 AM	4/27/88 April 27, 1988	NO

CAUSE OF DEATH

SEE INSTRUCTIONS

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. HEPATIC FAILURE
DUE TO (OR AS A CONSEQUENCE OF)
b. HEPATIC COMA
DUE TO (OR AS A CONSEQUENCE OF)
c. CIRRHOSIS OF LIVER
DUE TO (OR AS A CONSEQUENCE OF)
d. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death: 960 0420

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: GASTROINTESTINAL BLEEDING

28 WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

#17-421-7

CERTIFIER

29a CERTIFIER (Check only one)

[ ] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated

[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
Sirajuddin Khaja, M.D.	32657	April 27, 1988

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
S. Khaja, M.D. 5500 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Pemuda M.D.	APR 29 1988

CORONER OR MEDICAL EXAMINER 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
			001216

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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1

MARGARETTE N. CLEVELAND
LAKE COUNTY RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
APR 27 1988
SAM ORLICH
AUDITOR LAKE COUNTY

FILED