

\*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

127887  
Key# 23-124-22

Local No. 019395

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-193

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

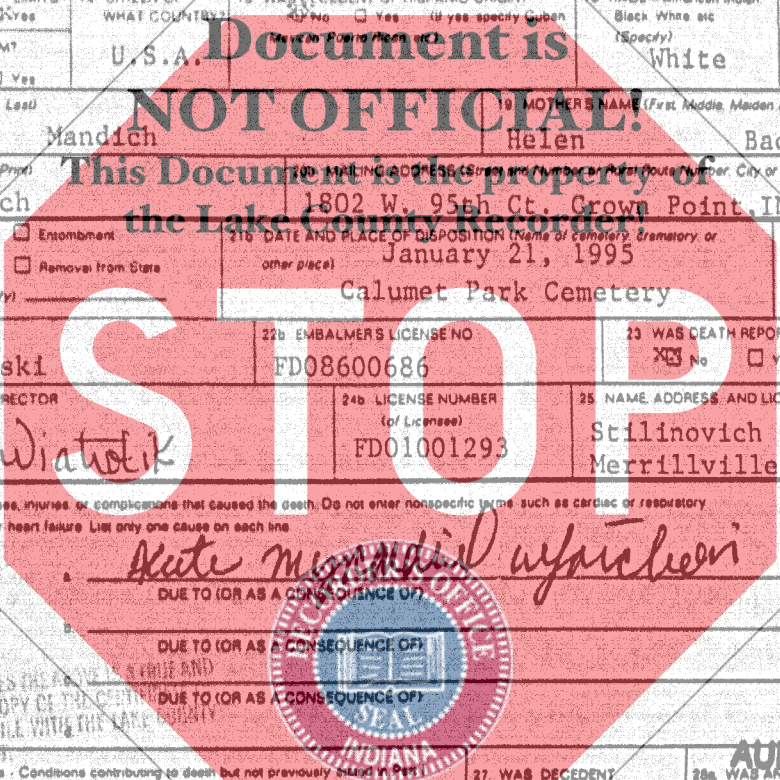
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Peter Mandich</b>		1 SEX <b>Male</b>	2a TIME OF DEATH <b>1:20 P.M.</b>	2b DATE OF DEATH (Month Day Year) <b>January 18, 1995</b>
4 SOCIAL SECURITY NUMBER <b>312-05-5260</b>	5a AGE—Last Birthday (Years) <b>79</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) <b>May 21, 1915</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Gary, IN.</b>	8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>	8c PLACE OF DEATH (Check any one and See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital - Southlake</b>		9b CITY, TOWN OR LOCATION OF DEATH <b>Merrillville</b>	9c COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Bernice Bastian</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Public Servant</b>	12b KIND OF BUSINESS/INDUSTRY <b>Lake County Governmen</b>	
13a RESIDENCE—STATE <b>IN.</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Crown Point</b>	13d STREET AND NUMBER <b>1802 W. 95th Ct.</b>	
13e ZIP CODE <b>46307</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (1-12) <b>12</b> College (1-4 or 5+1) <b>4</b>		18 FATHER'S NAME (First Middle Last) <b>Milan Mandich</b>		
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Helen Badovinac</b>		20a INFORMANT'S NAME (Type/Print) <b>Bernice Mandich</b>		
20b MARITAL ADDRESS (Street and Number or Post Office Number, City or Town, State, Zip Code) <b>1802 W. 95th Ct., Crown Point, IN 46307</b>		20c Relationship <b>EW</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>January 21, 1995 Calumet Park Cemetery</b>	21c LOCATION—City or Town, State <b>Merrillville, IN.</b>		
22a EMBALMER'S NAME <b>David Semplinski</b>	22b EMBALMER'S LICENSE NO. <b>FD08600686</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <b>Robert C. Wiatrolik</b>	24b LICENSE NUMBER (of License) <b>FD01001293</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Stilnovich &amp; Wiatrolik 7535 Laf Merrillville, IN. 46410</b>		
26 PART I: Enter the disease, 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. <b>Acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		
28a WAS AN AUTO ACCIDENT PERFORMED? (Yes or no) <b>No</b>		28b WAS AN AUTO ACCIDENT AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <b>Noguel White M.D.</b>		
29c MEDICAL LICENSE NO. <b>01028410</b>		29d DATE SIGNED (Month Day Year) <b>1/23/95</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Obaid 8895 Broadway Merrillville, IN. 46410 738-2081</b>				
31 HEALTH OFFICER'S SIGNATURE <b>Alexander D. Williams M.D.</b>				32 DATE FILED (Month Day Year) <b>January 24, 1995</b>
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	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.		



95010059

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
FEB 27 1995

FILED

FEB 17 1995

SAM ORLICH  
AUDITOR FOR LAKE COUNTY

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Street Andredman 9245 Calumet Ave. Muncie 46201

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