

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

Eleanor Dan
7729 Belmont
Hammond, IN 46324

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 2016-95

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TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

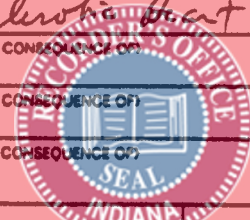
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Eli Dan		2 SEX Male	3a TIME OF DEATH 8:17A	3b DATE OF DEATH (Month Day Year) September 9, 1995
4 SOCIAL SECURITY NUMBER 310-22-7627A	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Nov. 11, 1926
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN	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) <input type="checkbox"/> Hospital <input type="checkbox"/> Institution <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) Community Hospital		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) Eleanor Kelemen	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) General Foreman	12b KIND OF BUSINESS/INDUSTRY Inland Steel	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 7129 Belmont	
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 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) 12		College (1-4 or 5+) 4		
18 FATHER'S NAME (First Middle Last) Axente Dan		19 MOTHER'S NAME (First Middle, Maiden Surname) Elisaveta Gragoin		
20a INFORMANT'S NAME (Type/Print) Eleanor Dan		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7129 Belmont, IN 46327	20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)	<input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Removal from State	21b DATE AND PLACE OF DISPOSITION (Date, Cemetery, or other place) September 12, 1995 Oak Hill Cemetery	21c LOCATION—City or Town, State Hammond, IN	
22a EMBALMER'S NAME James Porras	22b EMBALMER'S LICENSE NO. 1045964	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>	24b LICENSE NUMBER (of Licensee) 1045184	24c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321		
26 PART I: Enter the disease, injury, 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. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF)				
26 PART II: Other significant conditions (Conditions contributing to death but not previously stated in Part I) Diabetes mellitus Diabetic neuropathy				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN ANATOMY PERFORMED? (Yes or no) No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) ---
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 <i>[Signature]</i>			29c MEDICAL LICENSE NO. D1035700	29d DATE SIGNED (Month Day Year) Sept. 11, 1995
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (FORM 20) (Type/Print) M. Silverman, M.D. 6924 Indianapolis Blvd. Hammond, IN				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				31 DATE FILED (Month Day Year) September 11, 1995
32 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.		34i		

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STATE OF INDIANA LAKE COUNTY RECORDER

Key # 34-343-4

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