

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

Marie Gulasy ↑

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2405-95

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) STEVEN R. GULASY		2 SEX Male	3a TIME OF DEATH 2:20 P M	3b DATE OF DEATH (Month, Day, Yr.) October 20, 1995
4 SOCIAL SECURITY NUMBER 312-09-1373	5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) July 18, 1916
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? ----		8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not mentioned, give street and number) Community Hospital		9b 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) Marie Tuskan	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker		12b KIND OF BUSINESS/INDUSTRY Inland Steel
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 7954 Northcote Avenue	
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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College or 5+ 12th		18 FATHER'S NAME (First, Middle, Last) Steve Gulasy		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Helen Vischak		20a INFORMANT'S NAME (Type/Print) Marie B. Gulasy		
20b ADDRESS (Street, P.O. Box, R.F.D., etc.) (City or Town, State, Zip Code) 7954 Northcote Ave Hammond, Indiana 46324		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input checked="" 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) October 26, 1995 St. John Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME None		22b EMBALMER'S LICENSE NO. ----	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24 SIGNATURE OF FUNERAL DIRECTOR <i>Dean L. Wagner</i>		24b LICENSE NUMBER (of Licensee) 8800057	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME? Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, Indiana 46324	
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 <i>Brain Stem Stroke</i> 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.				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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)	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge and belief, 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 my examination and 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, 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>Sam Orlich</i>		29c MEDICAL LICENSE NO. 01031470	29d DATE SIGNED (Month, Day, Year) 10-24-95	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) John George, M.D. 7905 Calumet Avenue, Munster, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams</i>				32 DATE FILED (Month, Day, Year) October 24, 1995
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		33a DATE OF DEATH (Month, Day, Year) 10-20-95	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)
34a PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34b 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.		

DECEDENT

PARENTS

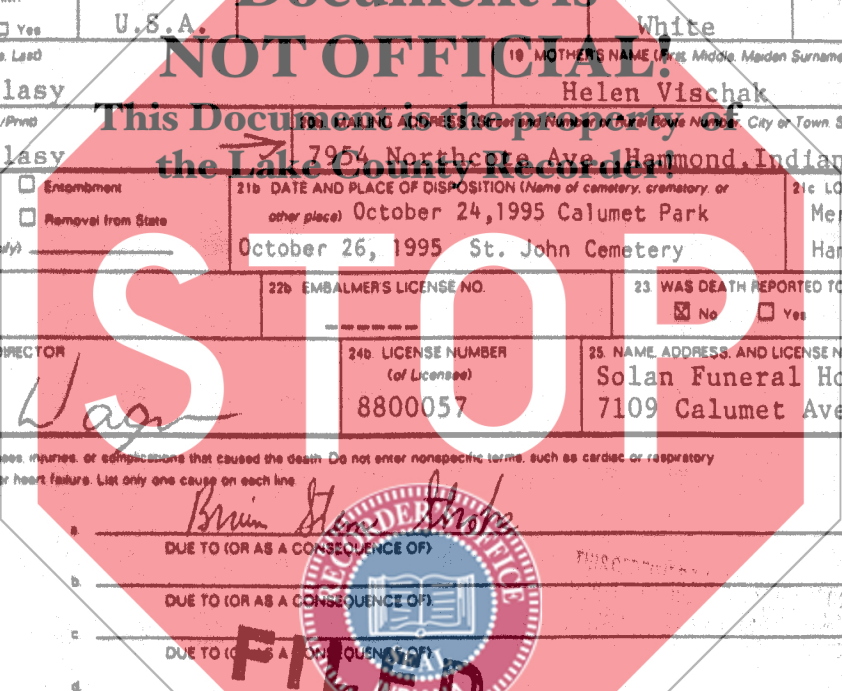
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



STATE OF INDIANA LAKE COUNTY FILED FOR RECORD OCT 26 PM 1:35 MARGARETTE CLIFLAND RECORDER

Handwritten initials and numbers: 05 900 JJ