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E 90 ft of W 973.7 ft of S 160 ft of SW SW S 10 T 35 R 8 0.331 AC Key #15-24-54 Unit #08

Local No. 2125-93

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): CHESTER C. LIPSKI
2. SEX: Male
3a. TIME OF DEATH: 10:47 AM
3b. DATE OF DEATH (Month, Day, Yr): September 3, 1993
4. SOCIAL SECURITY NUMBER: 316-14-0398
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): August 18, 1922
7. BIRTHPLACE (City and State or Foreign Country): Poland
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 ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hosital Southlake Campus
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Dorothy Vasko
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Wireman
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel Corp.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 265 E. 68th Place
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Lipski
19. MOTHER'S NAME (First, Middle, Maiden Surname): Kazimiera Olszewski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Dorothy Lipski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 265 E. 68th Pl., Merrillville, IN 46410
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 7, 1993 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO.: 1042372
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Johnnie Pruzin
24b. LICENSE NUMBER (of Licensee): 1007231
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE 083002453, 6360 Broadway, Merrillville, Indiana 46410

THIS CERTIFIES THAT THE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF THE CERTIFIER'S KNOWLEDGE AND BELIEF. FILED WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

PART I. Enter the chain of events, 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. Metastatic Cancer of Pancreas
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.
Approximate Interval Between Onset and Death: 1998

SEP 07 1993

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): 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):

CERTIFIER

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: Peter G. Mavrelis M.D.
29c. MEDICAL LICENSE NO.: 01030831
29d. DATE SIGNED (Month, Day, Yr): September 2, 1993

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Peter G. Mavrelis M.D., 8895 Broadway, Merrillville, Indiana 46410
31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): September 7, 1993

CORONER 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
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.

90 SW

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1