

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 CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT,
DEC 21, 1995 - *Franklin J. Remuda*
Date Issued Hammond Health Commissioner

Local No. 965

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19.3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) ANN YAKISH				2 SEX FEMALE		3a TIME OF DEATH 12:30 P.M.		3b DATE OF DEATH (Month, Day, Yr.) December 17, 1995			
4 SOCIAL SECURITY NUMBER 304-32-9604		5a AGE—Last Birthday (Year) 82		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr.) June 7, 1913			
7 BIRTHPLACE (City and State or Foreign Country) PENNSYLVANIA		8a WAS DECEDENT A U.S. VETERAN? NO									
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence									
9a FACILITY NAME (If not institution, give street and number) HAMMOND WHITING CONVALESCENT CENTER				9b CITY, TOWN, OR LOCATION OF DEATH HAMMOND (P.O. Whiting)		9c COUNTY OF DEATH LAKE					
10 MARITAL STATUS (Specify) WIDOWED		11 SURVIVING SPOUSE (If wife, give maiden name) N/A		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) COOK			12b KIND OF BUSINESS/INDUSTRY RESTAURANT				
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION HAMMOND (P.O. Whiting)			13d STREET AND NUMBER 1741 Brown Avenue				
13e ZIP CODE 46394		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		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 (10-12) 11 College (1-4 or 5+)									
18 FATHER'S NAME (First, Middle, Last) GEORGE PLUTKO					19 MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE (Maiden surname unknown)						
20a INFORMANT'S NAME (Type/Print) PAT ZATORSKI				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8788 Mathews Lane, Crown Point, IN 46307				20c Relationship Daughter			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <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) 21 December 1995 ELMWOOD CEMETERY				21c LOCATION—City or Town, State HAMMOND, INDIANA			
22a EMBALMER'S NAME THOS. OWENS				22b EMBALMER'S LICENSE NO. FDE 1001049		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thos Owens</i>				24b LICENSE NUMBER (of Licensee) FDE 1001049		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME OWENS FUNERAL HOME, 816-119th St., Whiting, IN 46394					
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. CEREBROVASCULAR ACCIDENT											
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF)											
b. DUE TO (OR AS A CONSEQUENCE OF)											
c. DUE TO (OR AS A CONSEQUENCE OF)											
d. DUE TO (OR AS A CONSEQUENCE OF)											
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I TIA CHF HTN H/OVD											
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO				28a. WAS AN AUTOPSY PERFORMED? NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A		28c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS			
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. 01034865		29d. DATE SIGNED (Month, Day, Year) DEC. 12-20-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Mahendra A Patel 535 Logan Drive #201C Hammond Ind 46321											
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Remuda, M.D.</i>								32. DATE FILED (Month, Day, Year) DEC 21 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				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. 000078							

33-145-15

STATE OF INDIANA
LAKE COUNTY
FILED
DEC 21 1995
10 DAYS

FILED