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

Local No. 2124-95

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): STEVEN KOVACIK, SR.
2. Sex: MALE
3a. Time of Death: 10:37PM
3b. Date of Death (Month Day Yr): SEPTEMBER 18, 1995
4. Social Security Number: 306-03-4844
5a. Age—Last Birthday (Years): 78
5b. Under 1 Year (Months / Days):
5c. Under 1 Day (Hours / Minutes):
6. Date of Birth (Mo Day Yr): FEB. 15, 1917
7. Birthplace (City and State or Foreign Country): EAST CHICAGO, IN
8a. Was Decedent a US Veteran? NO
8b. Year Last Served in US Armed Forces? N/A
9a. Place of Death (Check only one. See instructions): Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number): 2734 SCHRAGE AVENUE
9c. City, Town or Location of Death: WHITING
9d. County of Death: LAKE
10. Marital Status (Specify): MARRIED
11. Surviving Spouse (If wife, give maiden name): JULIA BLASKO
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired): ROLLER
12b. Kind of Business/Industry: INLAND STEEL COMPANY
13a. Residence—State: INDIANA
13b. County: LAKE
13c. City, Town or Location: WHITING
13d. Street and Number: 2734 SCHRAGE AVENUE
13e. Zip Code: 46394
13f. Inside City Limits: ☐ No ☒ Yes
13g. On a Farm? ☒ No ☐ Yes
14. Citizen of What Country? U.S.A.
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): 9; College (1-4 or 5+):

PARENTS

18. Father's Name (First Middle Last): LAWRENCE KOVACIK
19. Mother's Name (First Middle Maiden Surname): SUZANA DUBEK

INFORMANT

20a. Informant's Name (Type/Print): MRS. JULIA KOVACIK
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2734 SCHRAGE, WHITING, IN 46394
20c. Relationship: WIFE

DISPOSITION

21a. Method of Disposition: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place): SEPTEMBER 22, 1995 CALUMET PARK CEMETERY
21c. Location—City or Town, State: MERRILLVILLE, IN
22a. Embalmer's Name: MARTIN A. DYBEL
22b. Embalmer's License No.: FDE01019456
23. Was Death Reported to Coroner? ☐ No ☒ Yes
24a. Signature of Funeral Director: *Martin A. Dybel*
24b. License Number (of Licensee): FDE01019456
25. Name, Address and License Number of Funeral Home: BARAN & SON, INC., FDH83007267, 1235-119TH ST., WHITING, IN 46394

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. *Bladder Carcinoma*
DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Part II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: *Diabetes Mellitus*

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no): N/A
28a. Was an Autopsy Performed? (Yes or no): NO
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no): N/A

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: *Stuart M Klein MD*
29c. Medical License No: 01031797
29d. Date Signed (Month, Day, Year): SEPT. 20, 1995
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): STUART M. KLEIN, M.D., 7905 CALUMET AVENUE, MUNSTER, INDIANA 46321

HEALTH OFFICER

31. Health Officer's Signature:
32. Date Filed (Month, Day, Year): *September 22, 1995*

33. Manner of Death: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

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900 SK

Stamps: THIS CERTIFIES THE ABOVE IS A FULL AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. SEP 22 1995 — *Alexander S. ...* LAKE COUNTY HEALTH COMMISSIONER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 FEB ... RECORDER

AUDITOR LAKE COUNTY

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

CE#3400