

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure 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.

Local No. 40

ST. JAN 17, 1996
Date Issued *Franklin J. Bremuda*
Hammond Health Commissioner

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) George D Kotarski		2 SEX Male	3a TIME OF DEATH 10:55 pm	3b DATE OF DEATH (Month, Day, Yr) January 15, 1996	
4 *SOCIAL SECURITY NUMBER 309-24-8589	5a AGE—Last Birthday (Years) 66	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) June 15, 1929	
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN	8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1952	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy - North Campus		9c CITY, TOWN, OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mary Tower	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Fire Fighter	12b KIND OF BUSINESS/INDUSTRY Fire Dept.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 6709 Nebraska		
13e ZIP CODE 46323	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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) John Kotarski			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Julia Woz			20a INFORMANT'S NAME (Type/Print) Mary Kotarski		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6709 Nebraska, Hammond, IN 46323		20c Relationship Wife			
21a METHOD OF DISPOSITION <input 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) January 17, 1996 Oakland Memory Lanes		21c LOCATION—City or Town, State Dolton, IL	
22a EMBALMER'S NAME		22b EMBALMER'S LICENSE NO		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Michael M... ..</i>		24b LICENSE NUMBER (of Licensee) 10021419	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Mysliwy Funeral Home 3001619 4902 Reading Ave., East Chicago, IN 46312		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Metastatic Colon Cancer 17 Months			
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					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
		NO		SAM ORLICH NO	
NO AUDITOR LAKE COUNTY					
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>Jaw</i>			29c. MEDICAL LICENSE NO 40756	29d. DATE SIGNED (Month, Day, Year) JAN 1-16-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Ghassan Jaw, M.D. 905 Calmet Ave Muncie IN 46321					
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Bremuda M.D.</i>				32. DATE FILED (Month, Day, Year) JAN 17 1996	
33. 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
		34a. 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.			001459

FILED

FEB 29 1996