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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

Local No. 2877-95

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): Milivoje V. Milosavljevic
2. SEX: Male
3a. TIME OF DEATH: 10:30a.m.
3b. DATE OF DEATH (Month, Day, Yr.): December 18, 1995
4. *SOCIAL SECURITY NUMBER: 317-32-7227
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): March 6 1912
7. BIRTHPLACE (City and State or Foreign Country): Yugoslavia
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: n/a
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): 8406 Delaware Place
9c. CITY, TOWN OR LOCATION OF DEATH: Highland
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Charlotte Stoltze
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steelworker
12b. KIND OF BUSINESS/INDUSTRY: L T V Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Highland
13d. STREET AND NUMBER: 8406 Delaware Place
13e. ZIP CODE: 46322
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): n/a; College (1-4 or 5 +): 9

PARENTS

18. FATHER'S NAME (First, Middle, Last): Unavailable
19. MOTHER'S NAME (First, Middle, Maiden Surname): Unavailable

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Charlotte Milosavljevic
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8406 Delaware Pl.,Highland, IN
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): December 20, 1995 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: n/a
22b. EMBALMER'S LICENSE NO.: n/a
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: David J. Pastrick
24b. LICENSE NUMBER (of Licensee): FD08800012
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Oleska-Pastrick Funeral Home FH155, 3934 Elm St., East Chicago, IN 46312

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. Enter only one cause on each line.
Immediate cause (Final disease or condition resulting in death): a. Cancer of prostate with metastasis
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.
Approximate Interval Between Onset and Death: 1 yr.
PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

FILED DEC 21 1995 STATE OF INDIANA LAKE COUNTY RECORDER

SAM ORLICH
GARY, LAKE COUNTY

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): 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: x
29c. MEDICAL LICENSE NO: x IN 32599
29d. DATE SIGNED (Month, Day, Year): Dec 20, 1995

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Urmi P. Kalokhe, M.D. 5454 Hohman Avenue, Hammond, IN 46324
31. HEALTH OFFICER'S SIGNATURE: Donald D. Williams M.D
32. DATE FILED (Month, Day, Year): December 20, 1995

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.

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