upon Recording Mail to: Virgie Minarich 115 Madison Hobart IN 46342

100825

8 Reg 2 Vet 10 Total

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. .... State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	MICHAEL P. MINARICH
2 SEX	Male
3a TIME OF DEATH	3:00P M
3b DATE OF DEATH (Month Day Yr)	June 9, 1993
4 SOCIAL SECURITY NUMBER	316-09-0018
5a AGE—Last Birthday (Years)	80
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	JUL 8, 1912
7 BIRTHPLACE (City and State or Foreign Country)	RALPHTON, PENNSYLVANIA
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1946
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b FACILITY NAME (If not institution, give street and number)	115 MADISON STREET
9c CITY, TOWN OR LOCATION OF DEATH	HOBART
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	VIRGIE CRAWFORD
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	STRAIGHTENER
12b KIND OF BUSINESS/INDUSTRY	U.S. STEEL
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN OR LOCATION	HOBART
13d STREET AND NUMBER	115 MADISON STREET
13e ZIP CODE	46342
13f INSIDE CITY LIMITS	☐ No XX Yes
13g ON A FARM?	XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	X No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	8

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	MICHAEL MINARICH
19 MOTHER'S NAME (First Middle Maiden Surname)	JULIA RIMVEY

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	VIRGIE MINARICH
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	115 MADISON ST, HOBART, INDIANA 46342
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	X Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	JUN 12, 1993 EVERGREEN MEMORIAL PARK
21c LOCATION—City or Town, State	HOBART, INDIANA
22a EMBALMER'S NAME	JAMES J. KRAUSE
22b EMBALMER'S LICENSE NO	FDO1006463
23 WAS DEATH REPORTED TO CORONER?	☐ No X Yes
24a SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b LICENSE NUMBER (of Licensee)	FDO1006463
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

JUN 24 1993

[signature], M.D.

LAKE COUNTY HEALTH COMMISSIONER

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Vascular collapse	Unknown
DUE TO (OR AS A CONSEQUENCE OF) b.	Due to arteriosclerotic heart and vascular disease	
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

Sequentially list conditions, if any, which gave rise to the immediate cause. Enter underlying cause last.

Field	Entry
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)	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)	No

FILED

MAY 7 1996

SAM ORLICH AUDITOR LAKE COUNTY

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.
- Chief Deputy XX 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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Deborah Huseman
29c MEDICAL LICENSE NO	N/A
29d DATE SIGNED (Month Day Year)	June 14, 1993

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Deborah Huseman, Chief Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature], M.D.
32 DATE FILED (Month Day Year)	June 14, 1993

CORONER USE ONLY

Field	Entry
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)	June 9, 1993
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

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

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RECORDER'S OFFICE SEAL INDIANA
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