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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

1996 Local No. 4799-89

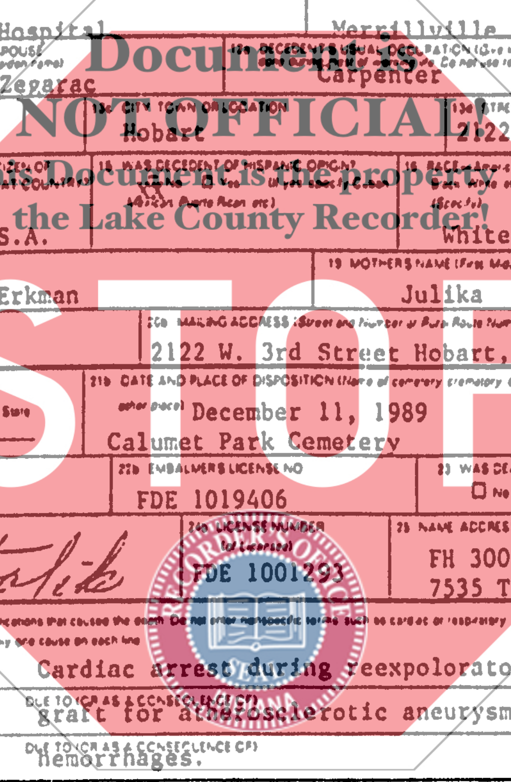
State No. ....

96061289

96 SEP 13 AM 8:44

RECORDER LAKE COUNTY

PRINT IN PERMANENT BLACK INK



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STOP

DECEDENT

Field	Entry
1 Decedent—Name (First Middle Last)	PETER ERKMAN
2 Sex	MALE
3a Time of Death	7:15P.M.
3b Date of Death (Month Day Yr)	December 7,1989
4 Social Security Number	268-12-9098
5a Age—Last Birthday (Years)	69
5b Under 1 Year (Months / Days)	
5c Under 1 Day (Hours / Minutes)	
6 Date of Birth (Month Day Yr)	May 29,1920
7 Birthplace (City and State or Foreign Country)	Girard, Ohio
8a Was Decedent a U.S. Veteran?	Yes
8b Year Last Served in US Armed Forces?	1946
9a Place of Death (Check only one)	HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b Facility Name (If not institution, give street and number)	Southlake Methodist Hospital
9c City, Town or Location of Death	Merrillville
9d County of Death	Lake
10 Marital Status (Specify)	Married
11 Surviving Spouse (If wife, give maiden name)	Joyce Zegarac
12a Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Carpenter
12b Kind of Business/Industry	Local #1005
13a Residence—State	Indiana
13b County	Lake
13c City, Town or Location	Hobart
13d Street and Number	2122 W 3rd Street
13e Zip Code	46342
13f Inside City Limits	☐ No XX Yes
13g On a Farm?	XX No ☐ Yes
14 Citizen of What Country	U.S.A.
15 Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX No ☐ Yes
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+)	

PARENTS

Field	Entry
18 Father's Name (First Middle Last)	Milosh Erkman
19 Mother's Name (First Middle Maiden Surname)	Julika Suitca

INFORMANT

Field	Entry
20a Informant's Name (Type/Print)	Joyce Erkman
20b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2122 W. 3rd Street Hobart,In. 46342
20c Relationship	Wife

DISPOSITION

Field	Entry
21a Method of Disposition	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b Date and Place of Disposition (Name of cemetery, crematory or other place)	December 11, 1989 Calumet Park Cemetery
21c Location—City or Town, State	Merrillville,Indiana
22a Embalmer's Name	Henry Blake
22b Embalmer's License No.	FDE 1019406
23 Was Death Reported to Coroner?	☐ No XX Yes
24a Signature of Funeral Director	Robert Wiatrolik
24b License Number (of Licensee)	FDE 1001293
25 Name, Address and License Number of Funeral Home	FH 3004455 Stilinovich & Wiatrolik 7535 Taft St. Merr., In. 46410

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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.	Cardiac arrest during reexpoloratory of abdominal	Unknown
b. Due to (or as a consequence of)	graft for atherosclerotic aneurysm with recurrent	
c. Due to (or as a consequence of)	hemorrhages.	
d. Due to (or as a consequence of)		

Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last.

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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)
	Yes	Yes

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.

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.

29b Signature and Title of Certifier	29c Medical License No.	29d Date Signed (Month Day Yr)
Daniel D Thomas	16120	Dec. 12, 1989

30 Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Dr. Daniel Thomas 2293 North Main St. Crown Point, Indiana

HEALTH OFFICER

31 Health Officer's Signature: [signature]

32 Date Filed (Month Day Yr): [illegible]

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

AUG 7 1996

[signature], M.D.
LAKE COUNTY HEALTH COMMISSIONER

David Wendell 300 c. 90th Ave. Mon. 46410

90 Zm

Ck# 11263