* 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.

Local No. 245

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): Ray Kotarski
2. SEX: Male
3a. TIME OF DEATH: 7:00a M
3b. DATE OF DEATH (Month Day, Yr): September 17, 1996
4. *SOCIAL SECURITY NUMBER: 316-18-6224
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): May 31, 1924
7. BIRTHPLACE (City and State or Foreign Country): DuBois, Pennsylvania
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
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): 5633 Wegg Avenue
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Stella Skorupa
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright
12b. KIND OF BUSINESS/INDUSTRY: Combustion Engineering
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 5633 Wegg Avenue
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: X 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): John Kotarski
19. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Wos

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Stella Kotarski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5633 Wegg Avenue, East Chicago, IND 46312
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 20, 1996 Chapel Lawn Memorial Gardens,
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: James H. Fife
22b. EMBALMER'S LICENSE NO.: FD01010795
23. WAS DEATH REPORTED TO CORONER?: ☐ No XX Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John P. Fife
24b. LICENSE NUMBER (of Licensee): FD01020366
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FIFE FUNERAL HOME - FH83001512 4201 Indpls.Blvd.,E.Chgo, IND

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. metastatic gastric carcinoma
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions if any, which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death

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): 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): -

CERTIFIER

29a. CERTIFIER (Check only one)
XX 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: [signature]
29c. MEDICAL LICENSE NO.: 133507
29d. DATE SIGNED (Month, Day, Year): Sept. 17, 1996
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Howard M. Mishoulam, M.D. - 1630 - 45th Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Rozkovich
32. DATE FILED (Month, Day, Year): 9-17-96

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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Key #30-594-25

FILED SEP 25 1996 SAM ORLICH AUDITOR LAKE COUNTY

96 SEP 25 AM 10 17 MARIE CLEVELAND RECORDER FILED FOR RECORD

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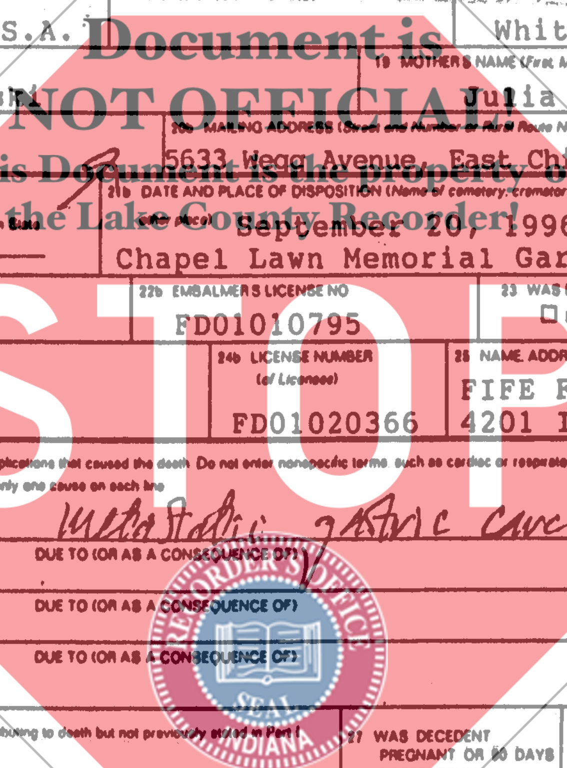

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1