David Schneider
905 Ridgeland
Munster 46321

* 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

Local No. 96-88 State No. 8

THIS RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): John G. Bogusz
2. SEX: Male
3a. TIME OF DEATH: 5:30A M
3b. DATE OF DEATH (Month, Day, Yr): March 25, 1996
4. *SOCIAL SECURITY NUMBER: 312-09-3585
5a. AGE—Last Birthday (Years): 83
5b. IF UNDER 1 YEAR: Months / Days
5c. IF UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): March 8, 1913
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, IN.
8a. WAS DECEDENT A U.S. VETERAN?: yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
8c. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
8d. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
8e. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
8f. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): married
11. SURVIVING SPOUSE (If wife, give maiden name): Emma Cifrea
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance
12b. KIND OF BUSINESS/INDUSTRY: Chemical
13a. RESIDENCE—STATE: IN.
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7515 Howard
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS? [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12; College (1-4 or 5+): ———

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Bogusz
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Wadas

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Emma Bogusz
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7515 Howard, Hammond, IN 46324
20c. Relationship: Wife

DISPOSITION

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): March 29, 1996 Chapel Lawn
21c. LOCATION—City or Town, State: Schererville, IN.
22a. EMBALMER'S NAME: James Porras
22b. EMBALMER'S LICENSE NO: 1045964
22c. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
23a. SIGNATURE OF FUNERAL DIRECTOR: Brian T. Burns
23b. LICENSE NUMBER (of Licensee): 860763
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish FH 8415 Calumet Ave Munster, IN 46321 #3004968

CAUSE OF DEATH

26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter mode/mode terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one entry on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Multiple myeloma
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. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Coronary Artery disease

27. WAS DECEDENT PREGNANT (Or in 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):
[X] 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: M. Ali M.D.
29c. MEDICAL LICENSE NO: 29762
29d. DATE SIGNED (Month, Day, Year): 3.26.96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print): Dr. M. Ali, M.D. 1630 45th Ave, Munster, IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Lankmeier
32. DATE FILED (Month, Day, Year): 9-29-96

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. [illegible] WORK?
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)
35. DATE PRONOUNCED DEAD (Month, Day, Year)
36. MOTOR VEHICLE ACCIDENT? (Yes or No) [illegible]

FILED
SEP 27 1996
SAM ORLICH
AUDITOR LAKE COUNTY

001248

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 SEP 27
MARGARET THEIS
RECORDER

CK# 3301