



\* ATTENTION ESTATE: The Social Security Act 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. **755**

## CERTIFICATE OF DEATH

Sep 19, 1996  
Date Issued *J. S. Remuda, M.D.*  
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

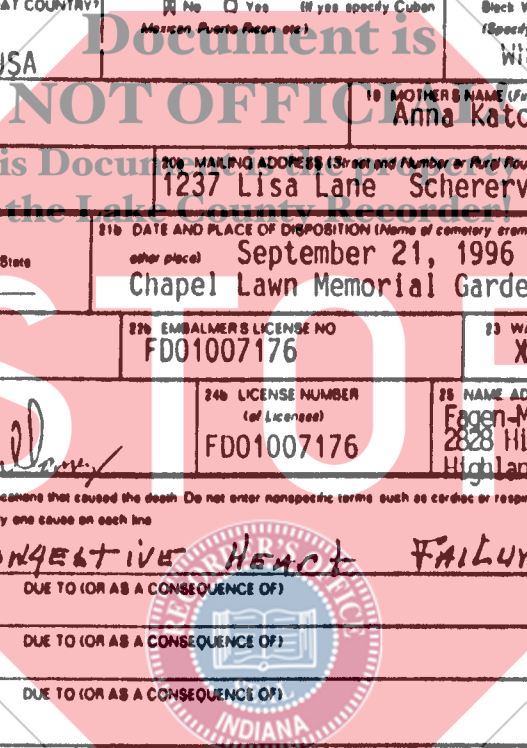
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Michael Adzima</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>1:10 a m</b>	3b DATE OF DEATH (Month Day Yr) <b>September 18, 1996</b>	
4 SOCIAL SECURITY NUMBER <b>306-01-7259</b>	5a AGE—Last Birthday (Years) <b>88</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>October 26, 1907</b>	
7a WAS DECEDENT A US VETERAN? <b>No</b>	7b YEAR LAST SERVED IN US ARMED FORCES? <b>NONE</b>	8 PLACE OF DEATH (Check only one box) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOR OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9a FACILITY NAME (If not institution give street and number) <b>St. Margaret Hospital</b>		9b CITY TOWN OR LOCATION OF DEATH <b>Hammond</b>	9c COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Widowed</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>NONE</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Supervisor</b>	12b KIND OF BUSINESS/INDUSTRY <b>Sinclair/Arco</b>		
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Highland</b>	13d STREET AND NUMBER <b>3507 Condit Street</b>		
13e ZIP CODE <b>46322</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>12</b> College (1-6 or 8+)		18 FATHER'S NAME (First Middle Last) <b>Michael Adzima</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Anna Katchmar</b>		20a INFORMANT'S NAME (Type/Print) <b>Judy Murphy</b>			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1237 Lisa Lane Schererville, Indiana 46375</b>		20c Relationship <b>Daughter</b>			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>September 21, 1996 Chapel Lawn Memorial Garden</b>		21c LOCATION—City or Town, State <b>Schererville, Indian.</b>	
22a EMBALMER'S NAME <b>Edward Mullaney</b>		22b EMBALMER'S LICENSE NO. <b>FD01007176</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward E. Mullaney</i>		24b LICENSE NUMBER (of Licensee) <b>FD01007176</b>	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Egan-Miller Funeral Homes FH83003035 2828 Highway Avenue Highland, Indiana 46322</b>		
26 PART I: Enter the deceased 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. <b>CONGESTIVE HEART FAILURE</b>				Approximate Interval Between Onset and Death <b>5 YEARS</b>	
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>CONGESTIVE HEART FAILURE</b>				DUE TO (OR AS A CONSEQUENCE OF)	
Conditions if any which gave rise to the immediate cause stating the underlying cause last				DUE TO (OR AS A CONSEQUENCE OF)	
PART II: Other significant conditions—Conditions contributing to death but not previously stated in Part I <b>DIABETES MELLITIS NEPHROSCLEROSIS RENAL FAILURE</b>					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>A. M. MA MD</i>			
29c MEDICAL LICENSE NO. <b>01018725</b>		29d DATE SIGNED (Month Day Year) <b>Sept 19/1996</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>E. Alt, M, D, 7550 Hohman Avenue, Munster, Indiana 46321</b>					
31 HEALTH OFFICER'S SIGNATURE <i>J. S. Remuda, M.D.</i>				32 DATE FILED (Month Day Year) <b>SEP 19 1996</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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, building, etc. (Specify)		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>FILED SEP 11 1996 SANDY HITTOR LAKE CO.</b>			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. <b>000111</b>			



Unit #26  
 Key #27-14-28  
 Pt W 1/2 E 1/2 NE SW S 22 T 36 R 9 C 14 AC