

\*ATTENTION: STATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.\*

INDIANA STATE DEPARTMENT OF HEALTH

Mary Linda Casey  
300 E. 90th Pr.  
Merr. IN. 464 10

Local No. 1045-95

CERTIFICATE OF DEATH

State No. 7

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

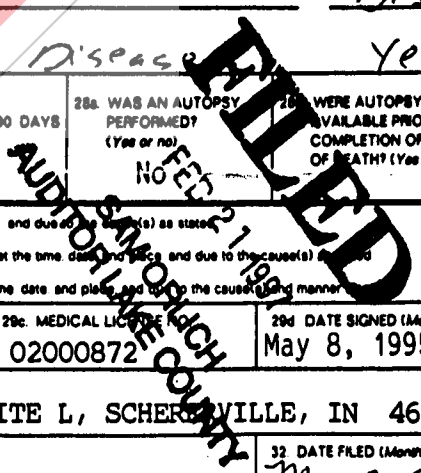
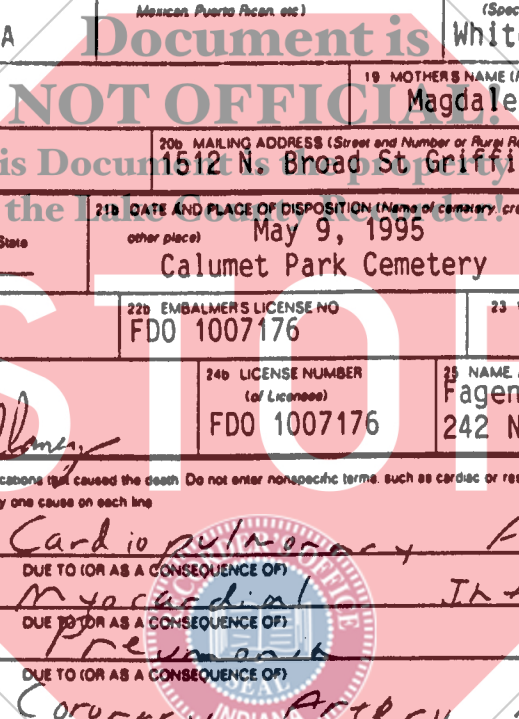
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Stanley Francis Lesniak		2 SEX Male		3a TIME OF DEATH 7:05 P M		3b DATE OF DEATH (Month, Day, Yr) May 5, 1995	
4 SOCIAL SECURITY NUMBER 311-32-8944		5a AGE—Last Birthday (Years) 87		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) March 6, 1908		7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES?		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) St Anthony Nursing Home				9c CITY, TOWN OR LOCATION OF DEATH Crown Point		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married		11 SURVIVING SPOUSE (If wife, give maiden name) Lucille Wisniewski		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pharmacist		12b KIND OF BUSINESS/INDUSTRY Pharmacy	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Griffith		13d STREET AND NUMBER 1512 N. Broad St	
13e ZIP CODE 46319		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> 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) <input type="checkbox"/> College (13 or 14) <input type="checkbox"/> 3		18 FATHER'S NAME (First, Middle, Last) John Lesniak			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Magdalen Mysliwiec				20a INFORMANT'S NAME (Type, Print) Lucille Lesniak			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 N. Broad St, Griffith, Indiana 46319				20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 9, 1995 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana			
22a EMBALMER'S NAME Edward F. Mullaney		22b EMBALMER'S LICENSE NO. FDO 1007176		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i>		24b LICENSE NUMBER (of Licensee) FDO 1007176		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens, Inc. 242 N. Griffith Blvd. Griffith, Indiana			
26 PART I Enter the deceased's 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) Cardio pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF) Myocardial Infarction Conditions if any which gave rise to the immediate cause stating the underlying cause last Pneumonia DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Disease 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)			
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) 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) 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) stated.							
29b SIGNATURE AND TITLE OF CERTIFIER <i>John A. Hoehn</i>				29c MEDICAL LICENSE NO. 02000872		29d DATE SIGNED (Month, Day, Year) May 8, 1995	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) JOHN A. HOEHN, D.O. 2001 SOUTH U.S. HWY 41, SUITE L, SCHERERVILLE, IN 46375							
31 HEALTH OFFICER'S SIGNATURE <i>John A. Hoehn</i>						32 DATE FILED (Month, Day, Year) May 8, 1995	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <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, office, building, etc. (Specify)			
		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 900 SW alt # 81001		34g DATE PRONOUNCED DEAD (Month, Day, Year)			
		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		1120-A			



FILED FOR RECORD  
MAY 21 1995  
MERRILLVILLE, INDIANA