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

Mary Linda Casey
300 E. 90th Dr.
Mer. IN. 464 10

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1045-95 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): 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 US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?:
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ 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 (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Lucille Wisnewski
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? ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): ; College (1 to 4 or 5 +): 3

PARENTS

18 FATHER'S NAME (First, Middle, Last): John Lesniak
19 MOTHER'S NAME (First, Middle, Maiden Surname): Magdalen Mysliwiec

INFORMANT

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

DISPOSITION

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): 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? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Edward F. Mullaney
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, IN 46319

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. Cardio pulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
d. Coronary Artery Disease

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

Interval Between Onset and Death: a. Seconds; b. Minutes; c. Hours; d. Days: 4 Years

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):
☒ 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) 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 stated.

29b SIGNATURE AND TITLE OF CERTIFIER: John A. Hoehn
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

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month, Day, Year): May 8, 1995

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: 9-00 SW
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): OK # 81001
34g DATE PRONOUNCED DEAD (Month, Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: 1120-A

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