* ATTENTION ESTATE: The Social Security # is being requested by this agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 70

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

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

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

JAN. 27, 1997 — Date Issued — Hammond Health Commissioner

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED — NAME (First Middle Last): JOHN M. YAGER
2 SEX: MALE
3a TIME OF DEATH: 1:23 PM
3b DATE OF DEATH (Month Day Yr): JANUARY 23, 1997
4 *SOCIAL SECURITY NUMBER: 306-01-8971
5a AGE—Last Birthday (Years): 81
5b UNDER 1 YEAR — Months / Days:
5c UNDER 1 DAY — Hours / Minutes:
6 DATE OF BIRTH (Mo. Day Yr): NOV. 15, 1915
7 BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution give street and number): ST. MARGARET MERCY HEALTHCARE CENTER
9c CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): ANN C. KOROLUK
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): PIPEFITTER
12b KIND OF BUSINESS/INDUSTRY: OIL REFINERY
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: WHITING
13d STREET AND NUMBER: 2800 SCHRAGE AVENUE
13e ZIP CODE: 46394
13f INSIDE CITY LIMITS? ☐ No XX Yes
13g ON A FARM? XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 6 — College (1-4 or 5+):

**PARENTS**

18 FATHER'S NAME (First Middle Last): FRANK YAGER
19 MOTHER'S NAME (First Middle Maiden Surname): ANNA KOLANKA

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): MRS. ANN C. YAGER
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2800 SCHRAGE AVENUE, WHITING, IN 46394/ WIFE
20c Relationship:

**DISPOSITION**

21a METHOD OF DISPOSITION: ☐ Burial XX Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JANUARY 28, 1997 OAKLAND MEMORY LANES
21c LOCATION (City or Town, State): DOLTON ILLINOIS
22a EMBALMER'S NAME: MARTIN A. DYBEL
22b EMBALMER'S LICENSE NO: FDE01019456
23 WAS DEATH REPORTED TO CORONER? ☐ No XX Yes
24a SIGNATURE OF FUNERAL DIRECTOR: M. A. Dybel
24b LICENSE NUMBER (of Licensee): FDE01019456
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH ST., WHITING, IN 463[illegible]

**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. CARDIAC ARRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF):
b. DIABETES MELLITUS
DUE TO (OR AS A CONSEQUENCE OF):
c. SEPSIS
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: JAN 28 1997

FILED
SAM ORLICH
AUDITOR LAKE COUNTY

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): N/A
28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

**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: Nardesai MD
29c MEDICAL LICENSE NO: 29300
29d DATE SIGNED (Month Day Year): JAN. 23, 1997

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): NITIN SARDESAI, M.D., 9307 CALUMET AVENUE, MUNSTER, INDIANA 46321

**HEALTH OFFICER**

31 HEALTH OFFICER'S SIGNATURE: Franklin J. Quesada M.D.
32 DATE FILED (Month Day Year): JAN 27 1997

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): 001111
34g DATE PRONOUNCED DEAD (Month Day Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

Beckam Kelly Smith attorneys at Law 5920 Hohman ave

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

Hammond IN 46320 · 2423

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