* 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. 0246-97 State No. .....

43e41

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1 DECEASED—NAME (First Middle Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
JOHN	CSMEREKA	MALE	5:40 P.M	JANUARY 30, 1997

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day. Yr)	7 BIRTHPLACE (City and State or Foreign Country)
312-14-2565	76			DEC. 21, 1920	EAST CHICAGO, INDIANA

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
YES	1943	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	ELIZABETH TURI KIS	ENGINEERING TECHNICIAN	INLAND STEEL COMPANY

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GRIFFITH	834 N. CLINE AVENUE

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
46319	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	WHITE	Elementary/Secondary (0-12): 0 - 12	College (1-4 or 5 +): 1+

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
MICHAEL CSMEREKA	MERI KOBOLICS

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
ELIZABETH CSMEREKA	834 N. CLINE AVE., GRIFFITH, IN 46319	WIFE

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
[X] Entombment [ ] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	FEBRUARY 3, 1997 ST JOHN CEMETERY MAUSOLEUM	HAMMOND, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
CHARLES W. WELLS	FD0104372	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
David L. Pastrick	FD08800012	OLESKA-PASTRICK FUNERAL HOME FH155 #(#$ ELM STREET, EAST CHICAGO, IN46312

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 Use only one cause on each line

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a Acute cardiopulmonary arrest	
DUE TO (OR AS A CONSEQUENCE OF)	b Ischemic brain damage secondary to #1	
Conditions if any which gave rise to the immediate cause (a) stating the underlying cause last	c Type II Diabetes	
DUE TO (OR AS A CONSEQUENCE OF)	d Hypertension	

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
C. McIntire DO	02001515	2-3.97

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

1573 N. Cline Ave Griffith IN 46319

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Alexander [illegible] MD	February 3, 1997

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c [illegible] (Yes or No)	34d DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)
	Apr 09 1997

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

FILED

SAM ORLICH
AUDITOR LAKE COUNTY

(illegible)

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

$5.00 cs 9.00