* 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.

Local No. 570

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

July 17, 1996 — Date Issued

[signature] — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Frank J. Shimala
2 SEX	Male
3a TIME OF DEATH	12:57 PM
3b DATE OF DEATH (Month Day Yr)	July 13, 1996
4 *SOCIAL SECURITY NUMBER	311-12-3999
5a AGE—Last Birthday (Years)	75
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo. Day Yr)	August 27, 1920
7 BIRTHPLACE (City and State or Foreign Country)	Whiting, Indiana
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	1945
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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)	Martha Ambrose
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Electrician
12b KIND OF BUSINESS/INDUSTRY	Amoco Oil Company
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	Hammond (Whiting P.O.)
13d STREET AND NUMBER	1626 Brown Avenue
13e ZIP CODE	46394
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Thomas Shimala
19 MOTHER'S NAME (First Middle Maiden Surname)	Agnes Gmerek

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Mrs. Martha Shimala
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1626 Brown Avenue, Whiting, IN 46394
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	July 17, 1996 St. John Cemetery
21c LOCATION—City or Town, State	Hammond, Indiana
22a EMBALMER'S NAME	Martin A. Dybel
22b EMBALMER'S LICENSE NO.	FDE01019456
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	FDE01019456
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Baran & Son, Inc., FDH83007267 1235-119th St., Whiting, IN 46394

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. Hemorrhagic shock, cause undetermined

DUE TO (OR AS A CONSEQUENCE OF)

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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

PART II Other significant conditions: Conditions contributing to death but not previously stated in Part I

Arteriosclerotic Heart Disease
Recent abdominal aortic aneurysm repair

Field	Entry
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)	N/A

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) 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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	James B Walsh MD
29c MEDICAL LICENSE NO.	27487
29d DATE SIGNED (Month Day Year)	7/15/96 Jul.15.199
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	JAMES B. WALSH MD · 5500 Hohman, Hammond, IN 46320

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Franklin D. [signature] M.D.
32 DATE FILED (Month Day Year)	July 17, 1996

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

001452

FILED APR 2 0 1998 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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

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