* 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. ..... State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): JOHN J. GRDINA, JR.

2 SEX: MALE

3a TIME OF DEATH: 6:35 AM

3b DATE OF DEATH (Month, Day, Yr.): MAY 13, 1997

4 *SOCIAL SECURITY NUMBER: 316-24-9204

5a AGE—Last Birthday (Years): 65

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo. Day. Yr.): JAN. 19, 1932

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? 1956

8c PLACE OF DEATH (Check only one. See instructions): HOSPITAL [XX] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9a FACILITY NAME (If not institution, give street and number): ST. CATHERINE HOSPITAL

9c CITY, TOWN OR LOCATION OF DEATH: EAST CHICAGO

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): MARRIED

11 SURVIVING SPOUSE (If wife, give maiden name): JOANNE HANES

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): DRAFTSMAN

12b KIND OF BUSINESS/INDUSTRY: A.C.A. INTERNATION

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN OR LOCATION: WHITING

13d STREET AND NUMBER: 1828 OLIVER STREET

13e ZIP CODE: 46394

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] 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): ; College (1-4 or 5 +): 4

PARENTS

18 FATHER'S NAME (First, Middle, Last): JOHN GRDINA

19 MOTHER'S NAME (First, Middle, Maiden Surname): LILLY VIOLET SASEK

INFORMANT

20a INFORMANT'S NAME (Type/Print): MRS. JOANNE GRDINA

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1828 OLIVER, WHITING, IN 46394

20c Relationship: WIFE

DISPOSITION

21a METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____ [ ] Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 16, 1997 ELMWOOD 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? [XX] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Martin 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. Cardio-respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. CVA
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

Approximate Interval Between Onset and Death

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:

29c MEDICAL LICENSE NO: 01032690

29d DATE SIGNED (Month, Day, Year): MAY 13, 1997

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SAMI AHMADZAI, M.D., 6924 INDIANAPOLIS BLVD., HAMMOND, IN 46324

31 HEALTH OFFICER'S SIGNATURE: Timothy Raykovich

32. DATE FILED (Month, Day, Year): 5-16-97

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 [illegible] HOW INJURY OCCURRED:

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):

34f LOCATION (Street and Number or R.F.D. 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.:

FILED
JUN 0 1 1997
SAM ORLICH
AUDITOR LAKE COUNTY 0001

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