10cc tufts

* 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. 1113-97   State No. ....

20155

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)	Joseph W. Myers
2 SEX	Male
3a TIME OF DEATH	7:47PM
3b DATE OF DEATH (Month Day Yr)	May 22, 1997
4 *SOCIAL SECURITY NUMBER	312-05-1773
5a AGE—Last Birthday (Years)	88
5b UNDER 1 YEAR Months Days	
5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr)	Dec 10, 1908
7 BIRTHPLACE (City and State or Foreign Country)	Gilchrist, Illinios
8a WAS DECEDENT A US VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1946
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	Southlake Methodist
9c CITY, TOWN OR LOCATION OF DEATH	Merrillville
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Betty Petro
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Steelworker
12b KIND OF BUSINESS/INDUSTRY	U.S. Steel
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Merrillville
13d STREET AND NUMBER	1817 W63rd Ave
13e ZIP CODE	46410-2338
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5+)	—

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	George Mayorski
19 MOTHER'S NAME (First Middle Maiden Surname)	Anne Ricamije

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Betty Myers
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1817 w 63rd Av. Merrillville, In 46410-2338
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	May 28, 1997 Calumet Park Cemetery
21c LOCATION—City or Town, State	Merrillville, Indiana
22a EMBALMER'S NAME	Leonard Gregorczyk
22b EMBALMER'S LICENSE NO	FD08800305
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Leonard Gregorczyk
24b LICENSE NUMBER (of Licensee)	FD08800305
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Stilinovich & Waitrolik FH83004455 7535 Taft St. Merrillville, In 46410

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Congestive heart failure

b. DUE TO (OR AS A CONSEQUENCE OF)

c. DUE TO (OR AS A CONSEQUENCE OF)

d. DUE TO (OR AS A CONSEQUENCE OF)

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

THIS CERTIFICATE ... IS A TRUE AND ... LAKE COUNTY HEALTH COMMISSIONER

Field	Entry
27 WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no)	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

FILED JUN 04 1997 SAM ORLICH AUDITOR LAKE COUNTY

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) 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	M. Gasparis MD
29c MEDICAL LICENSE NO	01037515
29d DATE SIGNED (Month Day Year)	5/24/97
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. M. Gasparis 1400 S. Lake Park Ave Hobart, In 46341 947-6045

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. ... MD
32 DATE FILED (Month Day Year)	May 29, 1997
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.	

15-179-5

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97035140 FILED FOR RECORD ... 29

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