

ATTENTION ESTATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Richard E Anderson
9211 Broadway
Merrillville, Ind 46410

Local No. 0713-96

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

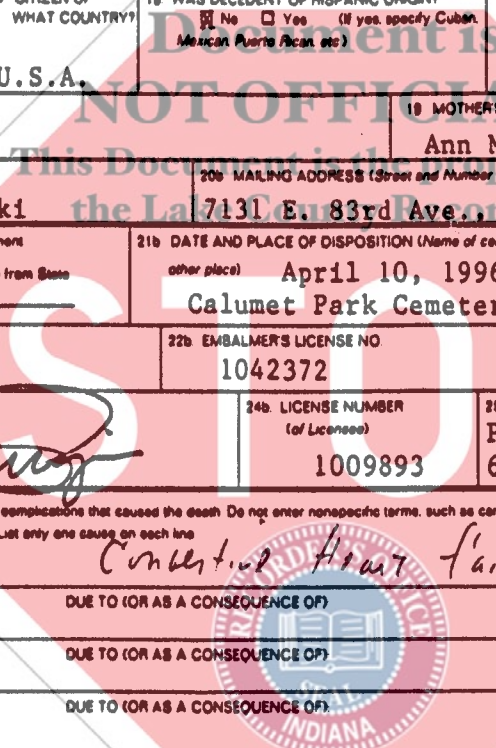
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) JOAN BRONOWSKI		2 SEX Female	3a TIME OF DEATH 8:24 Pm	3b DATE OF DEATH (Month Day, Yr) April 7, 1996	
4 *SOCIAL SECURITY NUMBER 311-26-0324	5a AGE—Last Birthday (Years) 67	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) August 9, 1928	
7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---	8c PLACE OF DEATH (Check only one See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) 6736 Van Buren Place		9b CITY, TOWN OR LOCATION OF DEATH Merrillville	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Eugene W. Bronowski	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker	12b KIND OF BUSINESS/INDUSTRY Own Home		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 6736 Van Buren Place		
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12 College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) Andrew Hornak			
19 MOTHER'S NAME (First Middle Maiden Surname) Ann McCrovitz		20a INFORMANT'S NAME (Type/Print) Terrence J. Bronowski			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7131 E. 83rd Ave., Crown Point, IN 46307		20c Relationship Son			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 10, 1996 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Charles W. Wells		22b EMBALMER'S LICENSE NO. 1042372	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) 1009893	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410		
26 PART I Enter the disease, 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. Coronary Heart Failure					
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF)					
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)					
DUE TO (OR AS A CONSEQUENCE OF)					
DUE TO (OR AS A CONSEQUENCE OF)					
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) No		28a. AUDITOR PERFORMED? (Yes or no) No	28b. AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. 01037515	29d. DATE SIGNED (Month, Day, Year) 040896		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Milton S. Gasparis, M.D., 1400 South Lake Park Avenue, Suite 301, Hobart, IN 46342					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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 APR 09 1996
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) <i>[Signature]</i>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



FILED

JUN 04 1997

SAM ORLICH

COMPLETE COPY OF THIS DEATH ON FILE IN THE OFFICE OF THE HEALTH OFFICER, LAKE COUNTY, INDIANA, APR 27, 1996

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Key #15-361-56

STATE OF INDIANA
LAKE COUNTY