

ATTENTION ESTATE: The Social Security # is 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

Mar 170 → John M. Voyak  
1629 Kennedy Ave  
Schererville, IN 46375

Local No. 205744  
TYPEPRINT IN PERMANENT BLACK INK

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

State No. ....

1 DECEASED—NAME (First Middle Last) <b>John Milan Voyak</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>5:38 A.M.</b>	3b DATE OF DEATH (Month Day, Yr) <b>October 31, 1997</b>	
4. SOCIAL SECURITY NUMBER <b>304-12-1209</b>	5a AGE—Last Birthday (Years) <b>85</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) <b>July 2, 1912</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a PLACE OF DEATH (Check only one. See instructions) <input checked="" 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 type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) <b>St. Margaret Mercy South</b>		9c CITY, TOWN OR LOCATION OF DEATH <b>Dyer</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Marie Domsic</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Pipefitter</b>		12b KIND OF BUSINESS/INDUSTRY <b>Chemical</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Schererville</b>		13d STREET AND NUMBER <b>390 Kennedy Avenue</b>	
13e ZIP CODE <b>46375</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>6</b> College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) <b>Stephen Voyak</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Frances Basar</b>		20a INFORMANT'S NAME (Type/Print) <b>Marie Voyak</b>			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>390 Kennedy Ave; Schererville, IN 46375</b>		20c Relationship <b>Wife</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>November 3, 1997 St. Michael Cemetery</b>		21c LOCATION—City or Town, State <b>Schererville, Indiana</b>	
22a EMBALMER'S NAME <b>Henry Blake</b>		22b EMBALMER'S LICENSE NO. <b>FDO1019406</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) <b>FDO1006015</b>		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Fagen-Miller Funeral Home FH83003035 2828 Highway Ave; Highland, IN 46322</b>	
26 PART I: State 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. <b>NOV 06 1997 M's metastatic carcinoma of lung Chronic obstructive pulmonary disease</b>					
26 PART II: Conditions (if any) which gave rise to the underlying disease causing the underlying disease. <b>Diabetes mellitus Primary carcinoma of lung</b>					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>					
28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>					
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)					
29 CERTIFIER (Check only one) <input 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.					
29a SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c MEDICAL LICENSE NO. <b>19054</b>		29d DATE SIGNED (Month, Day, Year) <b>11-4-97</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>CHARLES EGNAZ 1326 RT 30 SCHERERVILLE, IN</b>					
31 DEATH 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"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED <b>DEC 01 1997</b>
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) <b>SAM ORLICH AUDITOR LAKE COUNT</b>			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

STATE OF INDIANA  
LAKE COUNTY

FILED FOR REGISTRATION  
JULY ENTERED FOR REGISTRATION  
JULY ACCEPTANCE REGISTERED TRANSFER