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

MAR 0 2 1988 [signature] M.D.

Date Issued — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 205

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): ILIJA KATIC
2 SEX: MALE
3 DATE OF DEATH (Mo Day Yr): FEBRUARY 25, 1988
4 SOCIAL SECURITY NUMBER: 317 32 6598
5a AGE—Last Birthday (Years): 69
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Month, Day, Year): FEB. 6, 1919
7 BIRTHPLACE (City and State or Foreign Country): YUGOSLAVIA
8 YEAR LAST SERVED IN ARMED FORCES?: NO
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): 6506 Nevada Street
9c CITY, TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Dusanka
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: Components, Inc.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 6506 Nevada Street
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: No
13g ZIP CODE: 46323
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify
15 RACE—American Indian, Black, White, etc. (Specify): Serbian
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+) —

PARENTS

17 FATHER'S NAME (First, Middle, Last): Nikola Katic
18 MOTHER'S NAME (First, Middle, Maiden Surname): Marija Tutush

INFORMANT

19a INFORMANT'S NAME (Type/Print): Dusanka Katic
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6506 Nevada St Hammond, IN 46323
19c Relationship: Wife

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 29, 1988 Calumet Park
20c LOCATION—City or Town, State: Merrillville, IN
21a SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b LICENSE NUMBER (of Licensee): 1008300
22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Oleska Funeral Home (lic.#155) 3934 Elm ST, E.Chicago, IN 46312

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.
23a To the best of my knowledge, death occurred at the time, date and place stated. Signature and Title: [signature] MD
23b LICENSE NUMBER: 01034266
23c DATE SIGNED (Month, Day, Year): FEBRUARY 25, 1988

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 12:48PM
25 DATE PRONOUNCED DEAD (Month, Day, Year): FEBRUARY 25, 1988
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH (SEE INSTRUCTIONS)

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. CARCINOMA LUNG
DUE TO (OR AS A CONSEQUENCE OF)
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I
28a AUTOPSY PERFORMED?
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED 9708203 4
DEC 01 1997
SAM ORLICH
AUDITOR LAKE COUNTY

CERTIFIER (SEE INSTRUCTIONS)

29a CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 97 DEC -1 [illegible] MCGR[illegible]

29b SIGNATURE AND TITLE OF CERTIFIER: [signature] M
29c LICENSE NUMBER: 01025435
29d DATE SIGNED (Month, Day, Year): 3/2/88 (MARCH 2, 1988)
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): T RAYKOVICH MD

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month, Day, Year): MAR 0 2 1988

CORONER OR MEDICAL EXAMINER USE ONLY

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):

900 [initials] CS

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD I

CC010[illegible]