John Hoivnee
2606 Central Ave, Lake Station 46405

91-0139

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

No. .... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	JOHN HAMADY
2. SEX	Male
3a. TIME OF DEATH	6:50P M
3b. DATE OF DEATH (Month Day Yr)	February 14, 1991
4. SOCIAL SECURITY NUMBER	306-09-1578
5a. AGE—Last Birthday (Years)	72
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	JUNE 25, 1918
7. BIRTHPLACE (City and State or Foreign Country)	SPANGLER, PENNSYLVANIA
8a. WAS DECEDENT A U S VETERAN?	Yes
8b. YEAR LAST SERVED IN U S 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)	METHODIST HOSPITAL NORTHLAKE CAMPUS
9c. CITY, TOWN, OR LOCATION OF DEATH	GARY
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	CECELIA KOCIARA
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	MECHANIC
12b. KIND OF BUSINESS/INDUSTRY	GARY/HOBART WATER
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	LAKE STATTON
13d. STREET AND NUMBER	2301 CASS ST.
13e. ZIP CODE	46405
13f. INSIDE CITY LIMITS	☐ No X Yes
13g. ON A FARM?	X No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
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)	7
College (1-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last)	MICHAEL HAMADY
19. MOTHER'S NAME (First, Middle, Maiden Surname)	JULIA UHRINCHAK
20a. INFORMANT'S NAME (Type/Print)	CECELIA HAMADY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2301 CASS ST., LAKE STATTON, IN 46405
20c. Relationship	Wife
21a. METHOD OF DISPOSITION	X Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	FEB 18, 1991 CALVARY CEMETERY
21c. LOCATION—City or Town, State	PORTAGE, INDIANA
22a. EMBALMER'S NAME	JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.	FDO1004194
23. WAS DEATH REPORTED TO CORONER?	X No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FDO1006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 REES FUNERAL HOME 600 W. OLD RIDGE RD. HOBART, IN 46342

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

97 DEC 15 AM 9:37

MORRIS W. CARTER RECORDER

87085670

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Intracerebral bleed	2 days
DUE TO (OR AS A CONSEQUENCE OF): b.	Hypertension	Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

FILED DEC 1 1997

SAM ORLICH AUDITOR LAKE COUNTY

Field	Entry
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

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) 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	01035471
29d. DATE SIGNED (Month, Day, Year)	2.19.91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	209 E. 86th CT. MERRILLVILLE, IN 46410 DR. H. SHAH
31. HEALTH OFFICER'S SIGNATURE	Relina E Foster MD mph/ac
32. DATE FILED (Month, Day, Year)	FEB. 20 1991

CORONER ONLY

Field	Entry
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.	

000755

9.00

4 803778524