Danny Malesevic 4402 Sturgeon Valpo IN 4638

# INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2209-93

## CERTIFICATE OF DEATH

State No. .....

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
1993 SEP 21 AM 11:38

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

**TYPE/PRINT IN PERMANENT BLACK INK**

**DECEDENT**

1 DECEASED—NAME (First Middle Last): Wilhelmine Malesevic
2 SEX: Female
3a TIME OF DEATH: 6:45p M
3b DATE OF DEATH (Month Day Yr): September 6, 1993
4 SOCIAL SECURITY NUMBER: 349-97-8674
5a AGE—Last Birthday (Years): 66
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): June 16, 1927
7 BIRTHPLACE (City and State or Foreign Country): Germany
8a WAS DECEDENT EVER IN U.S. ARMED FORCES? No
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None
8c PLACE OF DEATH (Check only one See instructions): HOSPITAL X (Inpatient) ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9a FACILITY NAME (If not institution give street and number): St. Mary Medical Center
9c CITY TOWN OR LOCATION OF DEATH: Hobart
9e COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Djuro Malesevic
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: Self
13a RESIDENCE—STATE: IN.
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Lake Station
13d STREET AND NUMBER: 2256 Vermillion St.
13e ZIP CODE: 46405
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? X No ☐ 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 +):

**PARENTS**

18 FATHER'S NAME (First Middle Last): N/A
19 MOTHER'S NAME (First Middle Maiden Surname): N/A

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Djuro Malesevic
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2256 Vermillion St. Lake Station, IN. 46405
20c Relationship: Husband

**DISPOSITION**

21a METHOD OF DISPOSITION: X Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September 10, 1993 Calumet Park Cemetery
21c LOCATION—City or Town State: Merrillville, IN.
22a EMBALMER'S NAME: David Semplinski
22b EMBALMER'S LICENSE NO: FD08600686
23 WAS DEATH REPORTED TO CORONER? X No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b LICENSE NUMBER (of Licensee): FD01001293.
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Stilinovich & Wiatrolik 7535 [illegible] Merrillville, IN. 4641 FH300445

**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 | [illegible] | 7 days |
| Conditions if any which gave rise to the immediate cause stating the underlying cause last b | DUE TO (OR AS A CONSEQUENCE OF): [illegible] | [illegible] |
| c | DUE TO (OR AS A CONSEQUENCE OF): | |
| d | | |

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PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: [illegible]

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No
28a WAS AN AUTOPSY PERFORMED? (Yes or no) No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No

**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) 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
29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 01025771
29d DATE SIGNED (Month Day Year): 9-15-93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH-ITEM 26) (Type/Print): Dr. Ashback 4802 Broadway Gary, IN. 887-4950

**HEALTH OFFICER**

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32. DATE FILED (Month Day Year): September 16, 1993

**CORONER 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)
34g DATE PRONOUNCED DEAD (Month Day Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

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SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER PD 1