

ATTENTION STATE: The Social Security # is being 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

14034

CERTIFICATE OF DEATH

State No. **COMMUNITY TITLE COMPANY**
FILE NO **14034**

Local No. **101**

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) LILLIAN SARNECKI		2 SEX FEMALE	3a TIME OF DEATH 7:00 AM	3b DATE OF DEATH (Month, Day, Year) APR 28, 1997	
4 SOCIAL SECURITY NUMBER 315-16-7873	5a AGE—Last Birthday (Year) 72	5b UNDER 1 YEAR Months: _____ Days: _____	5c UNDER 1 DAY Hours: _____ Minutes: _____	6 DATE OF BIRTH (Mo., Day, Yr) JAN 2, 1925	
7 BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO	8a WAS DECEDENT A U.S. VETERAN? NO				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence <input checked="" type="checkbox"/>				
9a FACILITY NAME (If not institution, give street and number) 5018 WALSH AVE		9c CITY, TOWN OR LOCATION OF DEATH EAST CHICAGO	9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) WIDOW	11 SURVIVING SPOUSE (If wife, give maiden name) NONE	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 EAST CHICAGO	13d STREET AND NUMBER 5018 WALSH AVE		
13e ZIP CODE 46312	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	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) FRANK WOLAN		19 MOTHER'S NAME (First, Middle, Maiden Surname) AGNES PIESZCHALA			
20a INFORMANT'S NAME (Type/Print) JOHN J. SARNECKI		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 BLUEBIRD MUNSTER IN 46321	20c Relationship SON		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" 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) MAY 1, 1997 HOLY CROSS CEMETERY		21c LOCATION—City or Town, State CALUMET CITY IL	
22a EMBALMER'S NAME JAMES W. GHOLSTON		22b EMBALMER'S LICENSE NO. 1004194	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lewis</i>		24b LICENSE NUMBER (of Licensee) 1005491	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LESNIAK FH 3001601 4918 MAGOUN E. CHICAGO IN 46312		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Breast Cancer FILED Stage IV 2 months DUE TO (OR AS A CONSEQUENCE OF)			
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b. _____ DUE TO (OR AS A CONSEQUENCE OF) DEC 23 1997			
		c. _____ DUE TO (OR AS A CONSEQUENCE OF)			
		d. _____ DUE TO (OR AS A CONSEQUENCE OF)			
PART II Other significant conditions - Conditions contributing to death but not previously stated					
27a WERE ANY OTHER FINDINGS AVAILABLE TO CORONER OR CAUSE OF DEATH (Yes or no)		28 WAS AN AUTOPSY PERFORMED? (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. 01041301		29d DATE SIGNED (Month, Day, Year) 4/30/97			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) CHERYL MORGAN-IHRIG MD 1630 45TH ST MUNSTER IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Raykovich</i>				32 DATE FILED (Month, Day, Year) 4-30-97	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Fading Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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 001397
		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. 9-00 3201			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

97089314
97 DEC 30
STATE OF INDIANA
LAKE COUNTY
FILED FOR
CORONER
RD
10-47