

\* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. \*

INDIANA STATE DEPARTMENT OF HEALTH

KEY # 34-331-12

Local No. 49

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

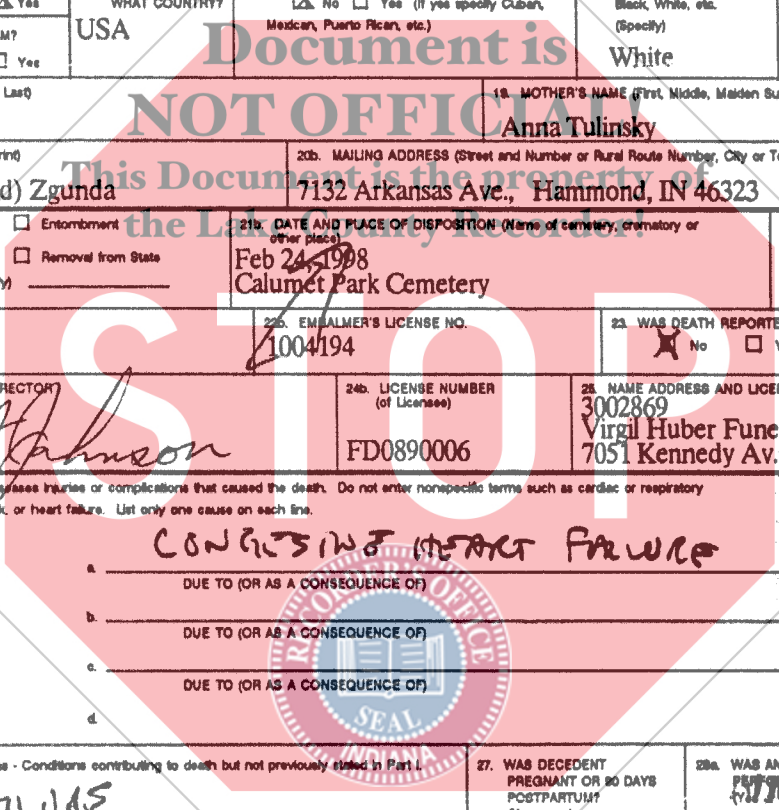
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First Middle Last) <b>Stephen Anthony Zgunda</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>7:22AM</b>	3b. DATE OF DEATH (Month Day Yr) <b>February 20, 1998</b>
4. SOCIAL SECURITY NUMBER <b>313-01-4998</b>	5a. AGE - Last Birthday (Years) <b>84</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) <b>Dec 31, 1913</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Whiting, IN 46394</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES <b>1946</b>	9a. PLACE OF DEATH (Check only one. See instructions)	
9b. FACILITY NAME (If not institution, give street and number) <b>St. Catherine Hospital</b>		9c. CITY TOWN OR LOCATION OF DEATH <b>East Chicago</b>		9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Geneva Gretencord</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Amaco Oil Lab Technician</b>		12b. KIND OF BUSINESS INDUSTRY <b>Petroleum Manufacturing</b>
13a. RESIDENCE - STATE <b>IN</b>	13b. COUNTY <b>Lake</b>	13c. CITY TOWN OR LOCATION <b>Hammond</b>	13d. STREET AND NUMBER <b>7132 Arkansas Ave</b>	
13e. ZIP CODE <b>46323</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 checked="" 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)		18. DECEDENT'S EDUCATION (Specify only highest grade completed)		
18. FATHER'S NAME (First, Middle, Last) <b>John Zgunda</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Tulinsky</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Geneva (Gretencord) Zgunda</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State—Zip Code) <b>7132 Arkansas Ave., Hammond, IN 46323</b>		20c. Relationship <b>Wife</b>
21. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21a. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Feb 24, 1998 Calumet Park Cemetery</b>		21b. LOCATION - City or Town State <b>Merrillville, Indiana</b>
22a. EMBALMER'S NAME <b>James W. Gholston</b>		22b. EMBALMER'S LICENSE NO. <b>1004194</b>		22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
23a. SIGNATURE OF FUNERAL DIRECTOR <i>Leopold Johnson</i>		23b. LICENSE NUMBER (of Licensee) <b>FD0890006</b>		23c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323</b>
24. 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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>CONGESTIVE HEART FAILURE</b>				
Conditions if any which gave rise to the immediate cause listing the underlying cause last				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>RENAL FAILURE</b>				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>				
28a. WAS AN AUTOPSY PERFORMED PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>NO</b>				
28b. WAS AN AUTOPSY FINDINGS REPORTED TO THE CORONER? <b>NO</b>				
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. <b>1027468</b>	29d. DATE SIGNED (Month Day Year) <b>2/23/98</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>George T. Asteris M.D., 2450 - 169th Street, Hammond, IN 46323</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Rayford</i>				32. DATE FILED (Month Day Year) <b>2-23-98</b>
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending 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) <b>NO</b>
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34e. 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. <b>NO</b>		



FILED  
APR 20 1998  
LAKELAND, INDIANA  
REC'D

SAM O'NEILL  
CORONER  
LAKE COUNTY

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