* **ATTENTION ESTATE:** 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.

Local No. 128

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1. DECEASED—NAME (First Middle Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month Day Yr) |
|---|---|---|---|
| Stella I. Urban | Female | 4:30p M | May 31, 1998 |

| 4. *SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR Months / Days | 5c. UNDER 1 DAY Hours / Minutes | 6. DATE OF BIRTH (Mo. Day Yr) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 306-24-9098 | 70 | | | Nov. 9, 1927 | East Chicago, Indiana |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See instructions) |
|---|---|---|
| No | - | HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) XX Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| 4130 Baring Avenue | East Chicago | Lake |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | Paul A. Urban | Cafeteria Worker | East Chicago Schools |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | East Chicago | 4130 Baring Avenue |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5 +) |
|---|---|---|---|---|---|---|---|
| 46312 | ☐ No XX Yes | ☒ No ☐ Yes | U.S.A. | ☒ No ☐ Yes | White | 12 | - |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Michael Kasczcyszyn | Tekla Kolibowski |

**INFORMANT**

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| Paul A. Urban | 4130 Baring Ave., East Chicago, IND 46312 | Husband |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____ | June 4, 1998 St. John Cemetery | Hammond, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| James H. Fife | FD01010795 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| John P. Fife | FD01020366 | FIFE FUNERAL HOME, INC. FH83001512 4201 Indpls. Blvd., East Chicago, IND |

**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. DECOMPENSATED CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF) | |
| | b. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE | |
| 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 JUN 16 1998

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) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|
| SAM ORLICH EDITOR LAKE COUNTY | | - |

**CERTIFIER**

29a. CERTIFIER (Check only one)

☒ 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 | 29c. MEDICAL LICENSE NO | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| ✓ Mgfra Mangahas MD | ✓ 0104512 | June 1, 1998 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Dr. M.C. Mangahas, M.D. - 4716 Indianapolis Blvd., East Chicago, IND 4631

**HEALTH OFFICER**

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month, Day, Year) |
|---|---|
| Dr. Timothy Raykovich | 6-2-98 |

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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) |
|---|---|
| | 001243 9.00 CM |

| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. |
|---|---|
| | # 03057187 M.D. |

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