* 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. 486

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jun 18 1998 — Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19.3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First Middle Last)	Andrew Slampyak
2. Sex	Male
3a. Time of Death	9:00 a.m.
3b. Date of Death (Month Day Yr)	June 15, 1998
4. *Social Security Number	306-01-7075
5a. Age—Last Birthday (Years)	86
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo Day Yr)	March 31, 1912
7. Birthplace (City and State or Foreign Country)	Czechoslovakia
8a. Was Decedent a U.S. Veteran?	NO
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If not institution give street and number)	St. Margaret Mercy
9c. City, Town or Location of Death	Hammond
9d. County of Death	Lake
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife give maiden name)	Ann Lypka
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Steelworker
12b. Kind of Business/Industry	Inland Steel
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town or Location	Hammond
13d. Street and Number	7139 Tapper Avenue
13e. Zip Code	46324
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	U.S.A.
15. Was Decedent of Hispanic Origin? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	10

PARENTS

Field	Entry
18. Father's Name (First Middle Last)	Stephen Slampyak
19. Mother's Name (First Middle Maiden Surname)	Anna Dwdrojnack

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Ann Slampyak
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7139 Tapper Ave., Hammond, IN. 46324
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory or other place)	June 17, 1998 St. Nicholas Cemetery
21c. Location—City or Town, State	Hammond, Indiana
22a. Embalmer's Name	Dean G. Wagner
22b. Embalmer's License No.	8800057
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	Dean G. Wagner (signature)
24b. License Number (of Licensee)	8800057
25. Name, Address and License Number of Funeral Home	Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN. 46324

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF)

b. Pulmonary emphysema

DUE TO (OR AS A CONSEQUENCE OF)

c. Chronic respiratory failure

DUE TO (OR AS A CONSEQUENCE OF)

d. Hepato Renal Syndrome

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. Approximate Interval Between Onset and Death

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: Chronic malnutrition; Chronic renal failure

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	Autopsy Performed? (Yes or no)	Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)
N/A	NO	N/A

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

Field	Entry
29b. Signature and Title of Certifier	(signature)
29c. Medical License No.	IN 26494
29d. Date Signed (Month Day Year)	6/18/98 June
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	J. Tan, M. D. 9038-b Columbia Avenue, Munster, Indiana, 46321

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Franklin J. Spremulli M.D. (signature)
32. Date Filed (Month Day Year)	June 18, 1998

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.	

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FILED JUN 22 — SAM ORLICH AUDITOR LAKE COUNTY

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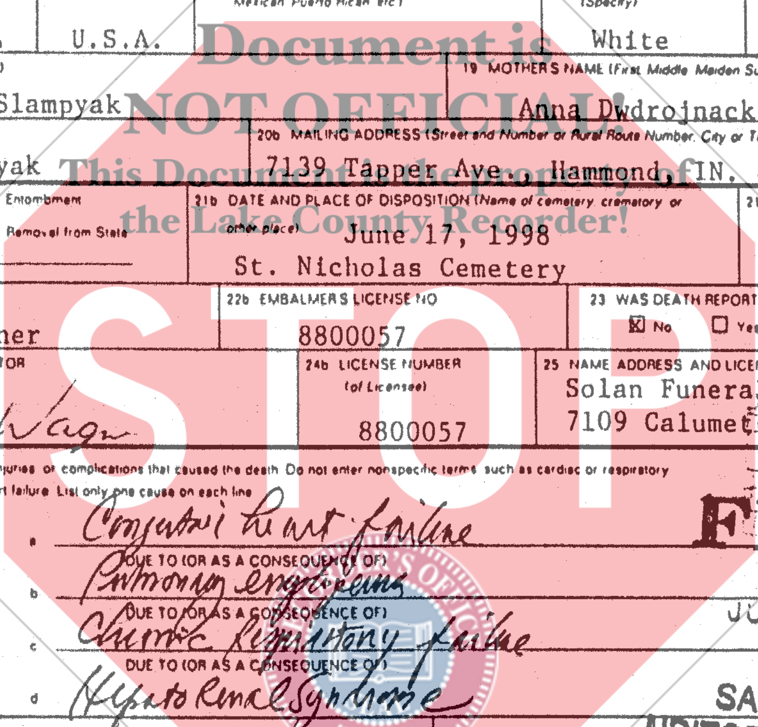

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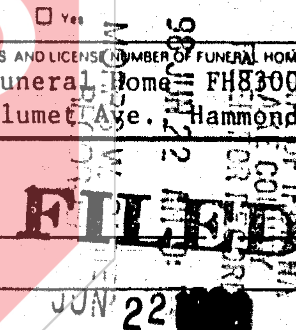

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1