Local No. 2254-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Dolores M. Zdrojeski
2 SEX: Female
3a TIME OF DEATH: 2:25P M
3b DATE OF DEATH (Month Day Yr): November 3, 1991
4 SOCIAL SECURITY NUMBER: 350-20-0280
5a AGE—Last Birthday (Years): 62
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day, Yr): AUG 15, 1929
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Anthony Medical Center
9c CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Daniel Zdrojeski
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: Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 7620 McCook Avenue
13e ZIP CODE: 46323
13f INSIDE CITY LIMITS: [ ] No [X] Yes
13g ON A FARM?: [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): Stanley Ciesielski
19 MOTHER'S NAME (First, Middle, Maiden Surname): Antoinetter Kabacinski

INFORMANT

20a INFORMANT'S NAME (Type/Print): Daniel Zdrojeski
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7620 McCook Ave. Hammond, IN 46323
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): NOV 6, 1991 St. Joseph Cemetery
21c LOCATION—City or Town, State: Hammond, Indiana
22a EMBALMER'S NAME: Charles D. Scheuer Jr.
22b EMBALMER'S LICENSE NO: 1006049
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: John V. Huber (signature)
24b LICENSE NUMBER (of Licensee): 1045362
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Brain Stem Compression	moments
DUE TO (OR AS A CONSEQUENCE OF) b	Cerebral Hemorrhage	Hours
DUE TO (OR AS A CONSEQUENCE OF) c	Thrombocytopenia	Hours

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions contributing to death but not previously stated in Part I

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):

THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
NOV 6 1991
Alexander S. Williams (signature)
LAKE COUNTY HEALTH COMMISSIONER

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: James R Miller MD
29c MEDICAL LICENSE NO: 01035142
29d DATE SIGNED (Month, Day, Year): 11/6/91
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): James R. Miller M.D., 521 East 86th Avenue, Merrillville, Indiana 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32 DATE FILED (Month, Day, Year): Nov. 6, 1991

CORONER USE ONLY

33 MANNER OF DEATH: [X] 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.

FILED
AUG 03 1999
PETER BENJAMIN
LAKE COUNTY AUDITOR
000259

99 AUG -3 PM 12: 1
MORRIS W. CARTER RECORDER
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

99061599

SBH06-004 State Form 10110 (R2/3-89) DEA CERT PD