

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

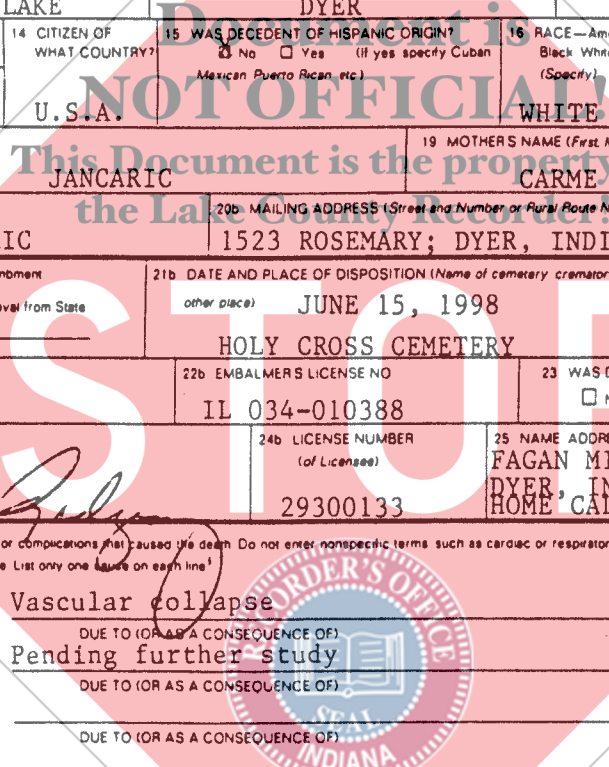
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) ROBERT J. JANCARIC		2 SEX MALE	3a TIME OF DEATH 12:52P M	3b DATE OF DEATH (Month, Day, Yr.) JUNE 11, 1998
4 *SOCIAL SECURITY NUMBER 320-36-8427	5a AGE—Last Birthday (Years) 55	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) OCTOBER 19, 1942
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? DNA		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution give street and number) METHODIST HOSPITAL		9c CITY TOWN OR LOCATION OF DEATH GARY	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) MARY ANN JENDER	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) STEEL WORKER		12b KIND OF BUSINESS/INDUSTRY U.S. STEEL
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION DYER	13d STREET AND NUMBER 1523 ROSEMARY	
13a ZIP CODE 46311	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) College (1-4 or 5+) 12		18 FATHER'S NAME (First, Middle, Last) JOSEPH JANCARIC		
19 MOTHER'S NAME (First, Middle, Maiden Surname) CARME CAVALLIER		20a INFORMANT'S NAME (Type/Print) MARY ANN JANCARIC		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1523 ROSEMARY; DYER, INDIANA 46311		20c Relationship WIFE		
21a 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)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) JUNE 15, 1998 HOLY CROSS CEMETERY		21c LOCATION—City or Town, State CALUMET CITY, IL
22a EMBALMER'S NAME LEO V. HENNESSY		22b EMBALMER'S LICENSE NO. IL 034-010388		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Mary Ann Jancaric</i>		24b LICENSE NUMBER (of Licensee) 29300133		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FAGAN MILLER FUNERAL HOME 1920 HART; DYER, IN FOR HENNESSY-NORRIS FUNERAL HOME CALUMET CITY, ILLINOIS
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 Vascular collapse DUE TO (OR AS A CONSEQUENCE OF) b Pending further study DUE TO (OR AS A CONSEQUENCE OF) c _____ DUE TO (OR AS A CONSEQUENCE OF) d _____ Conditions if any which gave rise to the immediate cause stating the underlying cause set				
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) No	28a WAS AN AUTOPSY PERFORMED? (Yes or no) Yes	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Pending
29a CERTIFIER Check only one: <input 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 checked="" type="checkbox"/> DEPUTY 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 Deputy				
29b SIGNATURE AND TITLE OF CERTIFIER <i>Deputy</i>		29c MEDICAL LICENSE NO. N/A	29d DATE SIGNED (Month, Day, Year) June 16, 1998	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307				
31 HEALTH OFFICER'S SIGNATURE <i>Peter Benjamin</i>			32 DATE FILED (Month, Day, Year) JUN 16 1998	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" 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) AUG 03 1999		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) PETER BENJAMIN LAKE COUNTY AUDITOR, etc		
34g DATE PRONOUNCED DEAD (Month, Day, Year) June 11, 1998		34h MOTOR VEHICLE ACCIDENT? (Yes or no) No.		000303

unit # 12
Key # 14-228-13
Sheffield Estates lot 105



99064571
99 AUG 11 4:00 PM
STATE OF INDIANA
CORONER
CARTER

9.00
E.P.
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