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

Key # 30-428-12

Local No. 760

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.

Oct. 15, 1999 — Date Issued — Hammond Health Commissioner

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

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 99 OCT 21 AM 9:17 MORRIS W. CARTER RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. Deceased—Name (First, Middle, Last): Robert J. Kowalik
2. Sex: Male
3a. Time of Death: 12:40 P.M.
3b. Date of Death (Month, Day, Yr): September 25, 1994
4. *Social Security Number: [illegible] (stamped 99086593)
5a. Age—Last Birthday (Years): 63
5b. Under 1 Year (Months, Days):
5c. Under 1 Day (Hours, Minutes):
6. Date of Birth (Mo, Day, Yr): June 22, 1931
7. Birthplace (City and State or Foreign Country): East Chicago, IN
8a. Was Decedent a U.S. Veteran?: Yes
8b. Year Last Served in US Armed Forces?: 1954
9a. Place of Death (Check only one. See instructions): Hospital ☐ Inpatient ☒ ER/Outpatient ☐ DOA; Other ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. Facility Name (If not institution, give street and number): St. Margaret Mercy Hospital - N Campus
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): Mary R. Pataky
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired): Machinist
12b. Kind of Business/Industry: L T V Steel Co.
13a. Residence—State: Indiana
13b. County: Lake
13c. City, Town or Location: Hammond
13d. Street and Number: 2826 Janet Street
13e. Zip Code: 46323
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): n/a; College (1-4 or 5+):

PARENTS

18. Father's Name (First, Middle, Last): John Kowalik
19. Mother's Name (First, Middle, Maiden Surname): Rose Nartovich

INFORMANT

20a. Informant's Name (Type/Print): Mary R. Kowalik
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2826 Janet St., Hammond, Indiana 46323
20c. Relationship: Wife

DISPOSITION

21a. Method of Disposition: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place): September 29, 1994 St John - St Joseph Cem/
21c. Location—City or Town, State: Hammond, Indiana
22a. Embalmer's Name: Charles W. Wells
22b. Embalmer's License No.: FD0104372
23. Was Death Reported to Coroner?: ☐ No ☒ Yes
24a. Signature of Funeral Director: [signature]
24b. License Number (of Licensee): FD08800012
25. Name, Address and License Number of Funeral Home: Oleska Pastrick Funeral Home 3934 Elm St., East Chicago, IN 46312

ARREDONDO

TICOR No 206816

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. Vascular collapse — Approximate Interval Between Onset and Death: Unknown

DUE TO (OR AS A CONSEQUENCE OF):
b. Due to arteriosclerotic heart and vascular disease

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 last.

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): No
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no): No

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: [illegible]
29c. Medical License No.: 538 B
29d. Date Signed (Month, Day, Year): September 26, 1994
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Dr. Thomas R. Philpot, D.P.M., Coroner, 2293 North Main St., Crown Point, Indiana 46307

HEALTH OFFICER

31. Health Officer's Signature: Franklin [illegible] M.D.
32. Date Filed (Month, Day, Year): SEP 28 1994

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): September 25, 1994
34h. Motor Vehicle Accident? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

FILED OCT 20 1999 9.00 [illegible]

PETER BENJAMIN LAKE COUNTY AUDITOR

001289

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