* 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.

Key #

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1333-98 State No. 17-310-10

200680

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): Joseph John Domsich	2. SEX: Male	3a. TIME OF DEATH: 6:17 A M	3b. DATE OF DEATH (Month, Day, Yr): June 5, 1998
4. SOCIAL SECURITY NUMBER: 306-38-9850	5a. AGE—Last Birthday (Years): 59 / 5b. UNDER 1 YEAR (Months, Days) / 5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo. Day, Yr): July 25, 1938	7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1963	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 Mary Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart	9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): Georgia Slavo	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Billing Clerk	12b. KIND OF BUSINESS/INDUSTRY: Sheet Metal Co
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Hobart	13d. STREET AND NUMBER: 634 Hidden Oak Trail 1B
13e. ZIP CODE: 46342	13f. INSIDE CITY LIMITS: ☐ No ☒ Yes / 13g. ON A FARM?: ☒ No ☐ Yes / 14. CITIZEN OF WHAT COUNTRY?: USA	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): Joseph F. Domsich	19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary A. Vavrecan

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Georgia Domsich	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 634 Hidden Oak Trail 1B Hobart, IN. 46342	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Calumet Park Cemetery June 8, 1998	21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Henry Blake	22b. EMBALMER'S LICENSE NO.: FDO 1019406	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): FDO 1006015	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Fagen-Miller Funeral Homes Inc FH83003035 2828 Highway Ave Highland, IN. 46322

CAUSE OF DEATH

28. 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. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary artery
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: Carcinoma Colon Diabetes

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: A. V. [signature] 29c. MEDICAL LICENSE NO.: 01037953 29d. DATE SIGNED (Month, Day, Year): 6/9/98

FILED

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): 7899 TAFT ST. MERRILLVILLE, IN.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alejandro S. Nilanes MD 32. DATE FILED (Month, Day, Year): June 9, 1998

FEB 03 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

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?	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.			

Dm
003799 .00
CS

2000 008155

FEB 03 2000

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2000 FEB -3

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

25 X