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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2338-93

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First Middle Last)	ROBERT A. PRONZE
2. SEX	Male
3a. TIME OF DEATH	4:20 PM
3b. DATE OF DEATH (Month Day Yr)	September 15, 1993
4. SOCIAL SECURITY NUMBER	316-09-1247
5a. AGE—Last Birthday (Years)	73
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo. Day. Yr)	March 21, 1920
7. BIRTHPLACE (City and State or Foreign Country)	Detroit, Michigan
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1946
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)	2710 Decatur Street
9c. CITY, TOWN OR LOCATION OF DEATH	Lake Station
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Anna S. Zakutansky
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Assembler
12b. KIND OF BUSINESS/INDUSTRY	Budd Company
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Lake Station
13d. STREET AND NUMBER	2710 Decatur Street
13e. ZIP CODE	46405
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+)	12

PARENTS

Field	Value
18. FATHER'S NAME (First, Middle, Last)	Paul Pronze
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Suzanna Mizerak

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	Anna S. Pronze
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2710 Decatur St., Lake Station, IN 46405
20c. Relationship	Wife

DISPOSITION

Field	Value
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)	September 18, 1993 St. Mary Russian Orthodox Cemetery
21c. LOCATION—City or Town, State	Gary, Indiana
22a. EMBALMER'S NAME	Charles W. Wells
22b. EMBALMER'S LICENSE NO	1042372
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 4641C

THIS CERTIFIES THE ABOVE TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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. Cardiac arrythmia

DUE TO (OR AS A CONSEQUENCE OF)

b. Coronary artery 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

Approximate Interval Between Onset and Death

SEP 20 1993

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

[signature], M.D.

LAKE COUNTY HEALTH COMMISSIONER

Field	Value
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)	

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	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO	29999
29d. DATE SIGNED (Month Day Year)	9/20/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Vidyadhar Gand[illegible], M.D., FACC, [illegible] Franciscan Drive, Crown Point, IN 46307

HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	[signature], MD
32. DATE FILED (Month Day Year)	September 20, 1993

FILED MAR 08 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

CORONER USE ONLY

Field	Value
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)	9:00 Am
34g. DATE PRONOUNCED DEAD (Month Day Year)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	866 OD

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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