

\* ATTENTION: The Social Security # is being requested by his 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  
LAKE COUNTY  
CERTIFICATE OF DEATH State No. ....

Local No. 0503-99

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) <b>WOLODYMYR BROWAR</b>		2000 026610		2000 APR 19 11 34 TIME OF DEATH <b>3:05 P.M.</b>		3b DATE OF DEATH (Month Day Year) <b>OCTOBER 30, 1999</b>	
4 SOCIAL SECURITY NUMBER <b>304-32-8824</b>		5a AGE—Last Birthday (Years) <b>85</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo. Day, Yr.) <b>March 22, 1914</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Ukraine</b>					
8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>-</b>		9a PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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) <b>Methodist Hospital-Southlake Campus</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>Merrillville</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS <b>Married</b>		11 SURVIVING SPOUSE (Specify) <b>Rostyslawa Buczacka</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during greater part of working life. Do not use retired) <b>Inspector</b>		12b KIND OF BUSINESS/INDUSTRY <b>Steel</b>	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN OR LOCATION <b>Merrillville</b>		13d STREET AND NUMBER <b>217 W. 56th. Place</b>	
13e ZIP CODE <b>46410</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>White</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-</b> College (1-4 or 5+) <b>3</b>					
18 FATHER'S NAME (First, Middle, Last) <b>Theodore Browar</b>				19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anastasia Lisowsak</b>			
20a INFORMANT'S NAME (Type/Print) <b>Rostyslawa Browar</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>217 W. 56th. Pl. Merrillville, IN 46410</b>		20c Relationship <b>Wife</b>			
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) <b>November 2, 1999 Calumet Park Cemetery</b>		21c LOCATION—City or Town, State <b>Merrillville, Indiana</b>			
22a EMBALMER'S NAME <b>Henry Blake</b>		22b EMBALMER'S LICENSE NO. <b>FD1019406</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward G. [Signature]</i>		24b LICENSE NUMBER (of Licensee) <b>FD08800305</b>		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>STILINOVICH &amp; WIATROLIK FH83004455 7535 Taft St. Merrillville, IN 46410</b>			
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. Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a <b>myocardial infarction</b>					
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b <b>coronary heart disease</b>					
		c <b>APR 13 2000</b>					
		d					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
<b>Hypertension</b>				<b>PETER BENJAMIN LAKE COUNTY ADDITOR</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	
						28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
29a CERTIFIER (Check only one) <input checked="" 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 type="checkbox"/> 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 <i>Billena</i>		29c MEDICAL LICENSE NO. <b>1026007</b>		29d DATE SIGNED (Month Day Year) <b>11-1-99</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>R. Billena, M.D. 5490 Broadway Merrillville, IN 46410 219-887-9549</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Billena, M.D.</i>						32 DATE FILED (Month Day Year) <b>November 3, 1999</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month Day Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
		34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>APR 05 2000 10:12 a.m. E.P.</b>			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, operator, etc. <i>Alexander S. Billena, M.D.</i> <b>LAKE COUNTY HEALTH COMMISSIONER</b>					

K A 39-464-8 012001594 #10 Hardest

