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

Local No. 206

33-190-1

STATE OF INDIANA
INDIANA STATE DEPARTMENT OF HEALTH

LAKE COUNTY RECORD

CERTIFICATE OF DEATH

2000 APR 20 PM 4:17

MORRIS W. CARTER

2000 027143

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAR 17 1995 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Joseph C. Dziadon
2. SEX	Male
3a. TIME OF DEATH	7:50A M
3b. DATE OF DEATH (Month, Day, Yr.)	March 11, 1995
4. SOCIAL SECURITY NUMBER	719-03-1467
5a. AGE—Last Birthday (Years)	78
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	JAN 13, 1917
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?	N/A
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)	7238 Marshall Avenue
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 Dziezak
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Bearing Machinist
12b. KIND OF BUSINESS/INDUSTRY	Steel
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hammond
13d. STREET AND NUMBER	7238 Marshall Avenue
13e. ZIP CODE	46323
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
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)	11
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Joachim Dziezak
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Julia Sroka

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Mary Dziadon
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7238 Marshall Avenue, Hammond, IN 46323
20c. Relationship	Wife

DISPOSITION

Field	Entry
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)	MAR 15, 1995 Holy Cross Cemetery
21c. LOCATION—City or Town, State	Calumet City, Illinois
22a. EMBALMER'S NAME	George J. Johnson
22b. EMBALMER'S LICENSE NO.	FD08900006
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Charles D. Scheuer, Jr. (signed)
24b. LICENSE NUMBER (of Licensee)	1006049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Bronchogenic Carcinoma	
DUE TO (OR AS A CONSEQUENCE OF): b.	With Brain Metastasis	1 year
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

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	N/A

FILED
APR 20 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	(signed)
29c. MEDICAL LICENSE NO.	01031582
29d. DATE SIGNED (Month, Day, Year)	March 13, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Lyle Munn M.D., 4321 Fir, East Chicago, IN 46312

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Franklin T. Fernandez M.D. (signed)
32. DATE FILED (Month, Day, Year)	March 14, 1995

Field	Entry
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)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

31230

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

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP
RECORDER'S OFFICE SEAL INDIANA