

INDIANA STATE BOARD OF HEALTH

Richard Adams  
5001 Tenn. St  
Gary, In. 46409

CERTIFICATE OF DEATH

Local No. 88-408

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING  
PHYSICIAN ONLY

ITEMS 24-26 MUST  
BE COMPLETED BY  
PERSON WHO  
PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF  
DEATH

SEE  
INSTRUCTIONS

CERTIFIER

HEALTH  
OFFICER

CORONER OR  
MEDICAL  
EXAMINER USE  
ONLY

1 DECEASED—NAME (FIRST MIDDLE LAST) <b>ANDREW G. EVANSECK</b>				2 SEX <b>Male</b>	3 DATE OF DEATH (Mo. Day Yr.) <b>June 20, 1988</b>
4 SOCIAL SECURITY NUMBER <b>306-09-6652</b>	5a AGE—Last Birthday (Years) <b>80</b>	5b UNDER 1 YEAR Months Days Hours Minutes	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) <b>Dec. 5, 1907</b>	7 BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Illinois</b>
8 YEAR EAST SERVED IN U.S. ARMED FORCES? <b>No</b>		9a PLACE OF DEATH (Check only one See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution, give street and number) <b>1323 Johnson Street</b>			9c CITY TOWN OR LOCATION OF DEATH <b>Gary</b>	9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS—Married Never Married Widowed, Divorced (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>June Semokaitis</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Supervisor</b>		12b KIND OF BUSINESS/INDUSTRY <b>U. Steel Corp.</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Gary</b>		13d STREET AND NUMBER <b>1323 Johnson Street</b>	
13e INSIDE CITY LIMITS? (Yes or no) <b>Yes</b>	13f FARM <b>No</b>	13g ZIP CODE <b>46407</b>	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes specify Cuban, Mexican Puerto Rican etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify	15 RACE—American Indian, Black White etc (Specify) <b>White</b>	16 DECEDENT'S EDUCATION (Specify highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>
17 FATHER'S NAME (First Middle Last) <b>Martin Evanseck</b>			18 MOTHER'S NAME (First Middle Maiden Surname) <b>Elizabeth Sakalich</b>		
19a INFORMANT'S NAME (Type, Print) <b>June Evanseck</b>		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State Zip Code) <b>1323 Johnson St., Gary, IN 46407</b>		19c Relationship <b>wife</b>	
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>June 24, 1988 Ridgeland Cemetery</b>		20c LOCATION—City or Town, State <b>Gary, Indiana</b>	
21a SIGNATURE OF FUNERAL DIRECTOR <i>John S. Pruzin</i>		21b LICENSE NUMBER (of Licensee) <b>1007231</b>	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410</b>		
23a To the best of my knowledge, death occurred at the time, date and place stated Signature and Title <		23b LICENSE NUMBER <b>25233</b>	DATE SIGNED <b>APR 2 1988</b>	DATE SIGNED <b>APR 2 1988</b>	
24 TIME OF DEATH <b>6:26 PM M</b>		25 DATE PRONOUNCED DEAD (Month Day Year) <b>June 20, 1988</b>		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER (Yes or No) <b>No</b>	
27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hypertensive Cardiovascular Disease</b>					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a <b>Hypertensive Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF)					
b _____ DUE TO (OR AS A CONSEQUENCE OF)					
c _____ DUE TO (OR AS A CONSEQUENCE OF)					
d _____ DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <b>Chronic Renal Insufficiency</b>					
28a WAS AN AUTOPSY PERFORMED? <b>No</b>			28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.					
29b SIGNATURE AND TITLE OF CERTIFIER <i>Richard Buyer, M.D.</i>			29c LICENSE NUMBER <b>25233</b>	29d DATE SIGNED (Month Day Year) <b>6.22.88</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Richard Buyer, M.D., 8895 Broadway, Merrillville, Indiana 46410</b>					
31 HEALTH OFFICER'S SIGNATURE <i>James T. Hedrick, Jr.</i>				32 DATE FILED (Month Day Year) <b>7 24 1988</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"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED <b>00644</b>
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) <b>900 CASH</b>		

