12cc

45-50-17

* **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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0050-98
257552

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	JOSEPH THOMAS DROZDA
2 SEX	Male
3a TIME OF DEATH	9:20A.M
3b DATE OF DEATH (Month Day Yr)	January 29, 1998
4 *SOCIAL SECURITY NUMBER	304-14-8191
5a AGE—Last Birthday (Years)	79
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	March 7, 1918
7 BIRTHPLACE (City and State or Foreign Country)	Munhall, PA.
8a WAS DECEDENT A U S VETERAN?	NO
8b YEAR LAST SERVED IN US ARMED FORCES?	None
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)	Southlake Methodist Hospital
9c CITY, TOWN OR LOCATION OF DEATH	Merrillville
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Mary Krochta
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Carpenter
12b KIND OF BUSINESS/INDUSTRY	U.S. Steel
13a RESIDENCE—STATE	Indiana
13b COUNTY	Porter
13c CITY, TOWN OR LOCATION	Valparaiso
13d STREET AND NUMBER	657 Northview Drive
13e ZIP CODE	46385
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): 12; College (1-4 or 5+):

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Joseph E. Drozda
19 MOTHER'S NAME (First Middle Maiden Surname)	Mary Krivy

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Mary Drozda
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	657 Northview Dr, Valparaiso, IN 46385
20c Relationship	Wife

DISPOSITION

Field	Entry
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)	February 2, 1998 St.Mary's Eastern Orthodox Cemetery
21c LOCATION—City or Town, State	Gary, Indiana
22a EMBALMER'S NAME	Robert Saul
22b EMBALMER'S LICENSE NO	FD29700098
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Michael A. Saul [signature]
24b LICENSE NUMBER (of Licensee)	FD29500093
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Stilinovich & Wiatrolik FH83004455 7535 Taft St. Merrillville, IN 46410

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF)
c. Arteriosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF)

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)	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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	R. H. Hovanessian M.D. [signature]
29c MEDICAL LICENSE NO	01023583
29d DATE SIGNED (Month Day Year)	2/4/98
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Hovanessian, 7863 Broadway Merrillville, IN 46410 219769-6639

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alejandro S. Hillines M.D. [signature]
32 DATE FILED (Month Day Year)	February 6, 1998

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	

DEATH ON FILE WITH THE LAKE CO. HEALTH DEPT
FEB 06 1998
Alejandro S. Hillines M.D.
LAKE COUNTY HEALTH COMMISSIONER
#1188
900

Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!
STOP
FILED
MAY 08 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR
2000 031316
2000 MAY -8 AM
MORRIS W. CARTER RECORDER