

INDIANA STATE DEPARTMENT OF HEALTH

Stanley Kuzydym  
5011 McGoun Ave  
East Chicago, IN 46312

Local No. 368

CERTIFICATE OF DEATH

State No. 46312

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) Walter F. Kuzydym		2 SEX Male	3a TIME OF DEATH 2:00P M	3b DATE OF DEATH (Month Day Yr) Dec. 23, 1993
4 SOCIAL SECURITY NUMBER 306-03-5443	5a AGE—Last Birthday (Year) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Dec. 30, 1913
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN.	8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) St. Catherine Hospital	9c CITY, TOWN OR LOCATION OF DEATH East Chicago, IN.	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Irene Bant	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Captain		12b KIND OF BUSINESS/INDUSTRY F.C. Dept.
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION East Chicago, IN.	13d STREET AND NUMBER 4226 Olcott Avenue	
13e ZIP CODE 46312	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5) <input type="checkbox"/> 12	18 FATHER'S NAME (First Middle Last) Frank Kuzydym			
19 MOTHER'S NAME (First Middle Maiden Surname) Marya Molek				20a INFORMANT'S NAME (Type/Print) Irene Kuzydym
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4226 Olcott Ave, E. Chicago, IN. 46312			20c Relationship Wife	
21a 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)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) December 27, 1993 Holy Cross Cem.		21c LOCATION—City or Town, State Calumet City, ILL.	
22a EMBALMER'S NAME James W. Gholston	22b EMBALMER'S LICENSE NO. FD01004194	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lesniak</i>	24b LICENSE NUMBER (of Licensee) FD01005491	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Lesniak #83001601 4918 Magoun, E. Chicago, IN. 46312		
26 PART I: Enter the disease, 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. <i>Acute Pericardial insufficiency</i> b. <i>Myocardial infarction</i> c. <i>Coronary heart failure</i> Conditions, if any, which gave rise to the immediate cause stating the underlying cause last d.				Approximate Interval Between Onset and Death 4:18
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I				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
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>D. Lloget</i>		29c MEDICAL LICENSE NO. 11-14608	29d DATE SIGNED (Month Day Year) 12-27-93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Raymond Lloget, 4320 Fir St. East Chicago, Indiana 46312				
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Jeremiah Karpovich</i>				32 DATE FILED (Month Day Year) 12-28-93
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) 6	34b TIME OF INJURY	34c INJURY AT WORK? (Yes) <b>FILED</b>	34d DESCRIBE HOW INJURY OCCURRED 9 W RASH
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) MAY 10 2000 PETER BENJAMIN LAKE COUNTY AUDITOR		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 1350		

Unit # 2H  
Key # 30-158-42  
Subdiv. NW S 32 T 37 R 9 lot 40 Block 2

