INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2167-93 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)	ROBERT SZWAJKOWSKI
2. Sex	Male
3a. Time of Death	4:00A.M.
3b. Date of Death (Month, Day, Yr)	September 8, 1993
4. Social Security Number	314-24-3350
5a. Age—Last Birthday (Years)	64
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	OCT 25, 1928
7. Birthplace (City and State or Foreign Country)	GARY, INDIANA
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in US Armed Forces?	1957
9a. Place of Death (Check only one)	Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	ST. MARY MEDICAL CENTER
9c. City, Town or Location of Death	HOBART
9d. County of Death	LAKE
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	MARY SAWA
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	TRUCK DRIVER
12b. Kind of Business/Industry	LEATH FURNITURE
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town or Location	HOBART
13d. Street and Number	1366 S. ILLINOIS STREET
13e. Zip Code	46342
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)	10
College (1-4 or 5+)	

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	WALTER SZWAJKOWSKI
19. Mother's Name (First, Middle, Maiden Surname)	STELLA FUSKO

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	MARY SZWAJKOWSKI
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1366 S. ILLINOIS ST, HOBART, IN 46342
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)	SEP 11, 1993 CALVARY CEMETERY
21c. Location—City or Town, State	PORTAGE, INDIANA
22a. Embalmer's Name	JAMES J. KRAUSE
22b. Embalmer's License No.	FDO1006463
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	James J. Krause
24b. License Number (of Licensee)	FDO1006463
25. Name, Address and License Number of Funeral Home	FH83003069 REES FUNERAL HOME, INC. 600 W. OLD RIDGE RD., HOBART, IN 46

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. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Obstructive lung disease
DUE TO (OR AS A CONSEQUENCE OF)
c.
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 contributing to death but not previously stated in Part I

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	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	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.

29b. Signature and Title of Certifier	29c. Medical License No.	29d. Date Signed (Month, Day, Year)
Charles J. Rebesco	01031652	9-13-93

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): CHARLES J. REBESCO MD, 1500 SOUTH LAKE PARK AVENUE, HOBART, INDIANA 46342

HEALTH OFFICER

31. Health Officer's Signature	32. Date Filed (Month, Day, Year)
Alexander S. Williams, MD	September 13, 1993

33. Manner of Death	34a. Date of Injury (Month, Day, Year)	34b. Time of Injury	34c. Injury at Work? (Yes or no)	34d. Describe How Injury Occurred
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER PO

01448

33701 9:00 AM

25x

Stamps and annotations:

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

MORRIS W. CARTER RECORDER

2000 052465

2000 JUL 25 PM 1:05

10 Req 2 Ver 12 Tot

THIS CERTIFIES THE ABOVE IS A TRUE COPY OF THE DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

SEP 13 1999

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
JUL 25 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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