

* 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

State No.

Local No. 1936-98

42863
TYPE/PRINT
IN
PERMANENT
BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Robert R. Plucinski		2. SEX Male	3a. TIME OF DEATH 8:00 A.M.	3b. DATE OF DEATH (Month, Day, Yr.) August 28, 1998	
4. SOCIAL SECURITY NUMBER 316-24-6338	5a. AGE—Last Birthday (Years) 68	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) Jan. 9, 1930	
7. BIRTHPLACE (City, State or Foreign Country) Wanatah, Indiana	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.) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		<input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) William J. Riley Hospice Residence		9c. CITY, TOWN, OR LOCATION OF DEATH Munster		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Vera Pridavok	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during major of working life. Do not use retired) Electrician		12b. KIND OF BUSINESS/INDUSTRY Steel Co.	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond		13d. STREET AND NUMBER 6806 Illinois Ave.	
13e. ZIP CODE 46320	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" 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) 10		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
18. FATHER'S NAME (First, Middle, Last) Frank Plucinski		19. MOTHER'S NAME (First, Middle, Maiden Surname) Olga Weijahn			
20a. INFORMANT'S NAME (Type/Print) Vera Plucinski		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 Illinois Ave. Hammond, Indiana		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) August 31, 1998 Catholic Cemeteries		21c. LOCATION—City or Town, State Hammond, Indiana	
22a. EMBALMER'S NAME Edgar Gleim		22b. EMBALMER'S LICENSE NO. FDO 1016173		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>		24b. LICENSE NUMBER (of Licensee) FDO 1014511	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500		
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. Metastatic Colon Cancer		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. FILED		Approximate Interval Between Onset and Death 9 Mos	
IMMEDIATE CAUSE (Final disease or condition resulting in death)		DUE TO (OR AS A CONSEQUENCE OF)			
Conditions, if any which gave rise to the immediate cause, stating the underlying cause last		DUE TO (OR AS A CONSEQUENCE OF)			
		DUE TO (OR AS A CONSEQUENCE OF)			
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. MEDICAL LICENSE NO. 01034701		29c. DATE SIGNED (Month, Day, Year) 9/1/98	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara L. Fuller, M.D.</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Barbara L. Fuller 9305 So. Calumet Ave Ste A1 Munster, IN 46321					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Skilimas MD</i>				32. DATE FILED (Month, Day, Year) September 1, 1998	
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 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. NO			