

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Local No. 456

CERTIFICATE OF DEATH

FILED JUNE 6, 2000
Date issued Hammond Health Commissioner

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

1 DECEASED—NAME (First Middle Last) STANLEY J. ZURAWSKI		2 SEX MALE	3a TIME OF DEATH 12:47 P.M.	3b DATE OF DEATH (Month Day Yr) JUNE 4, 2000	
4. *SOCIAL SECURITY NUMBER (Specify) 2000-055841		5a UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) SEPTEMBER 9, 1916	
7 BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA		8a WAS DECEDENT A U.S. VETERAN? NO			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? - N/A		8c PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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. MARGARET MERCY HOSPITAL		9c CITY, TOWN OR LOCATION OF DEATH HAMMOND	9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) VICTORIA SZCZERBOWSKI	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SUPERVISOR	12b KIND OF BUSINESS/INDUSTRY RAIL CAR COMPANY		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION HAMMOND	13d STREET AND NUMBER 4410 BALTIMORE AVENUE		
13e ZIP CODE 46327	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 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		18 FATHER'S NAME (First Middle Last) JOHN ZURAWSKI			
19 MOTHER'S NAME (First Middle Maiden Surname) MARY BROTON		20a INFORMANT'S NAME (Type/Print) VICTORIA ZURAWSKI			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 BALTIMORE AVE., HAMMOND, IN. 46327		20c Relationship WIFE			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) JUNE 7, 2000 HOLY CROSS CEMETERY		21c LOCATION—City or Town, State CALUMET CITY, ILLINOIS	
22a EMBALMER'S NAME KEITH D. ANTHONY		22b EMBALMER'S LICENSE NO. 01011911	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b LICENSE NUMBER (of Licensee) 01011911	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327		
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. <u>Myocardial Infarction</u> 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. 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>Rebecca Galante M.D.</i>		29c MEDICAL LICENSE NO. 01039908 IN	29d DATE SIGNED (Month Day Year) JUNE 5, 2000		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) REBECCA GALANTE M.D. 6924 INDIANAPOLIS BLVD., HAMMOND, IN. 46324					
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Serna M.D.</i>			32 DATE FILED (Month Day Year) JUNE 6, 2000		
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 INJURY OCCURRED
34a 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) <i>patrice galvin</i>		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 9231 Holman Ave HM. 46324			

FILED
PETER BENJAMIN
LAKE COUNTY AUDITOR
00629
1445
9.00.16