

*ATTENTION ESTATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. #0 379

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) STANLEY BROTKO		2. SEX MALE	3a. TIME OF DEATH 4:32 PM	3b. DATE OF DEATH (Month, Day, Yr) DECEMBER 25, 1993	
4. SOCIAL SECURITY NUMBER 313-07-6367		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) APR 19, 1914		7. BIRTHPLACE (City and State or Foreign Country) NEW CHICAGO, 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) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA 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'S HOSPITAL		9c. CITY, TOWN OR LOCATION OF DEATH EAST CHICAGO	9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) GERTRUDE MADRO	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) FACTORY WORKER		12b. KIND OF BUSINESS/INDUSTRY U.S. STEEL	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION LAKE STATION	13d. STREET AND NUMBER 4703 CENTRAL AVENUE		
13e. ZIP CODE 46405	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 checked="" 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 and highest grade completed) Elementary/Secondary (1-12) College (1-4 or 5+) 12		18. FATHER'S NAME (First, Middle, Last) STANLEY BROTKO SR.			
19. MOTHER'S NAME (First, Middle, Last) MARY NOVAK		20a. INFORMANT'S NAME (Type/Print) GERTRUDE BROTKO			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 CENTRAL AVE., LAKE STATION, IN 46405		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) DEC 29, 1993 CALUMET PARK CEMETERY		21c. LOCATION—City or Town, State MERRILLVILLE, INDIANA	
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FDO1006463	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOME, INC. 600 W. RIDGE RD., HOBART, IN 46344		
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) <i>Acute Respiratory Distress Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Tracheo-bronchial Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Hypoxemic Respiratory Distress</i> 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) N/A		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>Ramon P. Llobet MD</i>		29c. MEDICAL LICENSE NO. 14608	29d. DATE SIGNED (Month, Day, Year) 1/7/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) RAMON P. LLOBET MD, 4320 FIR STREET, SUITE 410, EAST CHICAGO, INDIANA 46312					
31. HEALTH OFFICER'S SIGNATURE <i>Ramon P. Llobet MD</i>		32. DATE FILED (Month, Day, Year) AUG 8 2000		32. DATE FILED (Month, Day, Year) 1-12-94	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Cause not to be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK?	34d. DESCRIBE HOW INJURY OCCURRED PETER BENJAMIN LAKE COUNTY AUDITOR
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. 00646			

file 9:00
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