

INDIANA STATE BOARD OF HEALTH
LAKE COUNTY
CERTIFICATE OF DEATH FILED FOR State No.

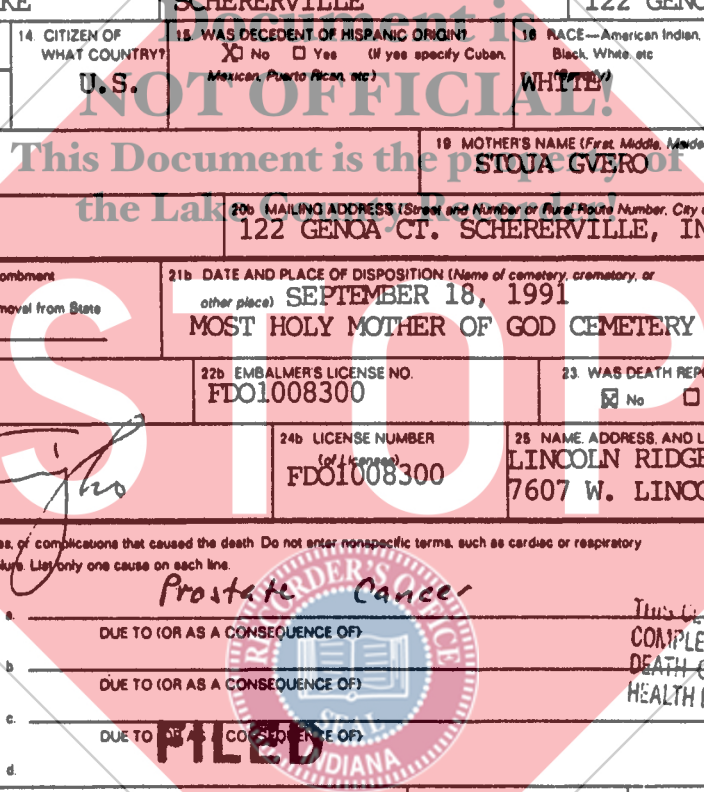
Local No.

1889-91

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) VOJKO DJURIC		2 SEX MALE		3 TIME OF DEATH 9:56 P M		4 DATE OF DEATH (Month, Day, Yr) SEPTEMBER 15, 1991	
4 SOCIAL SECURITY NUMBER 304-34-4031		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) JUNE 1912		7 BIRTHPLACE (City and State or Foreign Country) YUGOSLAVIA					
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE		9a PLACE OF DEATH (City, State, etc. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Residency			
9b FACILITY NAME (If not permanent, give street and number) OUR LADY OF MERCY HOSPITAL		9c CITY, TOWN OR LOCATION OF DEATH DYER		9d COUNTY OF DEATH LAKE			
10 MARITAL STATUS MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) STAKA SERDIC		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) STEELWORKER RETIRED		12b KIND OF BUSINESS/INDUSTRY INLAND STEEL COMPANY	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION SCHERERVILLE		13d STREET AND NUMBER 122 GENOA CT.	
13e ZIP CODE 46375		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	
16 FATHER'S NAME (First, Middle, Last) DANE DJURIC		17 MOTHER'S NAME (First, Middle, Maiden Surname) STOJA GVERO					
18 FATHER'S NAME (First, Middle, Last) DANE DJURIC		19 MOTHER'S NAME (First, Middle, Maiden Surname) STOJA GVERO		20a INFORMANT'S NAME (Type/Print) STAKA DJURIC		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 GENOA CT. SCHERERVILLE, 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) SEPTEMBER 18, 1991 MOST HOLY MOTHER OF GOD CEMETERY		21c LOCATION—City or Town, State GRAYSLAKE, ILLINOIS	
22a EMBALMER'S NAME ELI VUJKO		22b EMBALMER'S LICENSE NO. FDO1008300		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Eli Vučko</i>		24b LICENSE NUMBER (of Licensee) FDO1008300		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IND.			
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. Prostate Cancer		IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.		APPROXIMATE Interval Between Onset and Death			
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I AUG 18 2000		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)	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN PETER BENJAMIN LAKE COUNTY AUDITOR <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		29b SIGNATURE AND TITLE OF CERTIFIER <i>P. S. Drasga</i>		29c MEDICAL LICENSE NO. 01031484		29d DATE SIGNED (Month, Day, Year) September 16, 1991	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) RAY E. DRASGA, M.D., 8127 Merrillville Road, Merrillville, Indiana 46410							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>						32 DATE FILED (Month, Day, Year) Sept. 16, 1991	
33 MANNER OF DEATH <input checked="" 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) 900 E. 1 C1316 CS			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

LOT 64, CASA BELLA, SECOND ADDITION TO THE TOWN OF SCHERERVILLE, AS RECORDED IN PLAT BOOK 57, PAGE 78



THIS IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



Official Stamp

2000 060061-62-63

Document Mail Back to
Information Sheet

This is where you want the recorded document sent back to
when it has completed the recording process.

Name NIKOLA DJURIC

Address 122 GENOA CT.

City St Zip SCHERERVILLE, IN. 46375

Telephone 1-219-322-1989

Signature Printed _____

Signature Written _____

Date of Signature _____

Check Number _____

Check Amount _____

Cash 27.00

Office Use Only

Check Equals Amount Due Yes No

Total _____

Initials _____