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.

Local No. 2210-97

32049

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

2000 068159

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JOHN W. STACHON
2. SEX: MALE
3a. TIME OF DEATH: 5:50 A.M.
3b. DATE OF DEATH (Month, Day, Yr): OCTOBER 17, 1997
4. SOCIAL SECURITY NUMBER: 305-20-1594
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): OCTOBER 12, 1925
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): ROSE MARKOVICH
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): POLICE OFFICER
12b. KIND OF BUSINESS/INDUSTRY: POLICE OFFICER
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 5082 W. 85TH. LN.
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): STANLEY STACHON
19. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA WILK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): ROSE STACHON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5082 W.85TH.LN.CROWN POINT,IN. 46307
20c. Relationship: WIFE

DISPOSITION

P.O. Box 7 893 Crown Point 46308

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☒ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): OCTOBER 21, 1997 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: CHARLES WELLS
22b. EMBALMER'S LICENSE NO.: FD01042372
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01008300
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME 88800070 7607 W.LINCOLN HWY.CROWN POINT,IN.46307

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. Heart failure
DUE TO (OR AS A CONSEQUENCE OF) b. Coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF) c.
DUE TO (OR AS A CONSEQUENCE OF) d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

SEP 19 2000

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Aortic valve disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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): —

FILED SEP 2000

PETER BENJAMIN LAKE COUNTY AUDITOR

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: [signature] M.D.
29c. MEDICAL LICENSE NO.: 010-25644
29d. DATE SIGNED (Month, Day, Year): 10-23-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 8687 Connecticut Street Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alejandro S. Williams M.D.
32. DATE FILED (Month, Day, Year): Oct. 24, 1997

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

9.00 E.I. CS

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1