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# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Local No. 2687-92 State No. ..........

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

TYPE/PRINT IN PERMANENT BLACK INK

2002 001590

**DECEDENT**

1. DECEASED—NAME (First, Middle, Last): LAZO KECMAN
2. SEX: MALE
3a. TIME OF DEATH: 2:30 PM
3b. DATE OF DEATH (Month, Day, Yr): DECEMBER 22, 1992
4. SOCIAL SECURITY NUMBER: 317-60-7665
5a. AGE—Last Birthday (Years): 54
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo, Day, Yr): 4-9-1938
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?
9a. 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): THE COMMUNITY HOSPITAL
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): GOSPOVA POPOVIC
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MACHINIST
12b. KIND OF BUSINESS/INDUSTRY: EUCLID MACHINE&TOOL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: MUNSTER
13d. STREET AND NUMBER: 9958 REDBUD ST.
13e. ZIP CODE: 46321
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
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): OBRAD KECMAN
19. MOTHER'S NAME (First, Middle, Maiden Surname): BOJA MARIJANOVIC

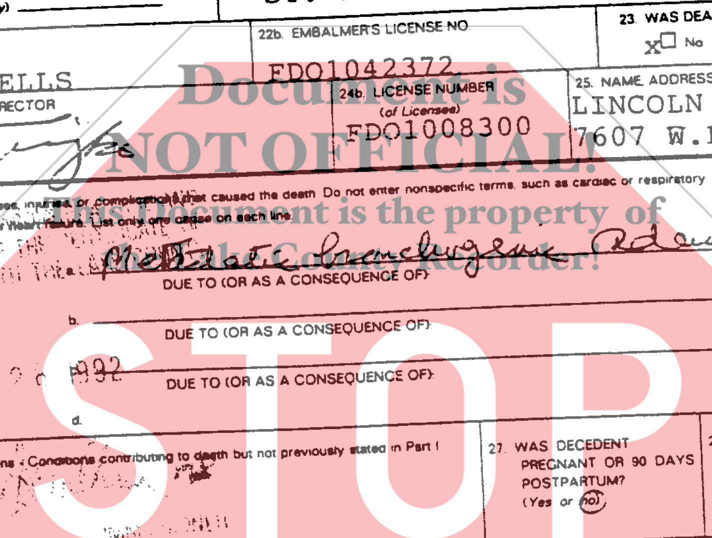
**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): GOSPOVA KECMAN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9958 REDBUD ST. MUNSTER, INDIANA
20c. Relationship: WIFE

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 12-24-1992 ST. MARYS CEMETERY
21c. LOCATION—City or Town, State: GARY, INDIANA
22a. EMBALMER'S NAME: CHARLES WELLS
22b. EMBALMER'S LICENSE NO: FDO1042372
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO1008300
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE F.H. 88800070 7607 W.LINCOLN HWY.CROWN POINT,

**CAUSE OF DEATH**

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STOP


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. Metastatic adenocarcinoma [handwritten]
DUE TO (OR AS A CONSEQUENCE OF): b.
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


THIS CERTIFIES THAT THIS IS A COMPLETE COPY OF THE ... ON FILE WITH THE ... HEALTH DEPT ... DEC 2 6 1992


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)
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

**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]
29c. MEDICAL LICENSE NO.: 27970
29d. DATE SIGNED (Month, Day, Year): DECEMBER 23, 199
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. SALMAN GAILANI, M. D. 9116 COLUMBIA AVENUE MUNSTER, INDIANA 46321

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): December 28, 199

**CORONER USE ONLY**

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) ... pedestrian, etc.


FILED
JAN 4 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR
9.00
000286
J #1200



Stewart Title Services
of Northwest Indiana
8695 Broadway
Merrillville, IN 46410
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