S- 620012714 AKA used

Key #16-27-352-11

Local No. 2684-90

# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First Middle Last): ILIJA (ELI) DUKICH
2 SEX: MALE
3a TIME OF DEATH: 8:39 P.M.
3b DATE OF DEATH (Month Day Yr): DECEMBER 28, 1990
4 SOCIAL SECURITY NUMBER: 317-32-7499
5a AGE—Last Birthday (Years): 64
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo. Day Yr): NOVEMBER 14, 1926
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 ☐ Other (Specify) ☐ Residence
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): ZORKA DUKICH
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RETIRED FOREMAN STEEL INDUS.
12b KIND OF BUSINESS/INDUSTRY: INLAND STEEL COMP.
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: HIGHLAND
13d STREET AND NUMBER: 3112 E. 99TH. ST.
13e ZIP CODE: 46322
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? ☐ 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): DANE DUKICH
19 MOTHER'S NAME (First, Middle, Maiden Surname): DJUKA SERDAR

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): ZORKA DUKICH
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3112E. 99TH. ST. HIGHLAND, IND 46322
20c Relationship: WIFE

**DISPOSITION**

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 31, 1990 CALUMET PARK CEMETERY
21c LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a EMBALMER'S NAME: ELI VUJKO
22b EMBALMER'S LICENSE NO.: FDO 1008300
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR:
24b LICENSE NUMBER (of Licensee): 1008300
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IND

**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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute Myocardial
DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery dise
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

Approximate Interval Between Onset and Death

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)
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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:
29c MEDICAL LICENSE NO: 24802
29d DATE SIGNED (Month, Day, Year): JANUARY 2, 199

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. WAHBI ADAD, M. D. 8320 KENNEDY AVENUE HIGHLAND, INDIANA 46322

**HEALTH OFFICER**

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month, Day, Year): Jan 2, 1991

**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) If yes, specify driver, passenger, pedestrian, etc.

000785

SF#06-104 State Form 10110 (R2 / 89) DEA CERT NO.: