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

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INDIANA STATE DEPARTMENT OF HEALTH 49-223-7#8

Local No.....

CERTIFICATE OF DEATH

State No.....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED--NAME (First Middle Last): Raymond Marion Augustyn
2. SEX: Male
3a. TIME OF DEATH: 10:05PM
3b. DATE OF DEATH (Month Day Yr): December 25, 2001
4. SOCIAL SECURITY NUMBER: 314-26-9142
5a. AGE - Last Birthday (Years): 72
5b. UNDER 1 YEAR Months Days: 2002 02 1360
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): September 8, 1929
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, IN 46312
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 ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital, Northlake
9c. CITY TOWN OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Catherine Agnes Hero
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Switchman
12b. KIND OF BUSINESS INDUSTRY: Steel Manufacturing
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 2620 West Oakwood Drive
13e. ZIP CODE: 46406
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): Anthony Augustyn
19. MOTHER'S NAME (First, Middle, Maiden Surname): Otillie Czarneski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Catherine Agnes Augustyn
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2620 West Oakwood Drive, Gary, IN 46406
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): December 28, 2001 Chapel Lawn Memorial Gardens
21c. LOCATION - City or Town State: Schererville, Indiana
22a. EMBALMER'S NAME: Henry Blake
22b. EMBALMER'S LICENSE NO.: FD1019406
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Robert T Hallett
24b. LICENSE NUMBER (of Licensee): FD29700058
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19900009 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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 INFARCTION
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

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): 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: Miguel A. Gambetta
29c. MEDICAL LICENSE NO: 25594
29d. DATE SIGNED (Month Day Year): 12/27/1

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr.Miguel A. Gambetta, 7217 Indianoplis Blvd., Hammond, IN 46323

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month Day Year): JAN 08 2002

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

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SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1