

* 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.

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. 0618-99

State No. _____

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

205509
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

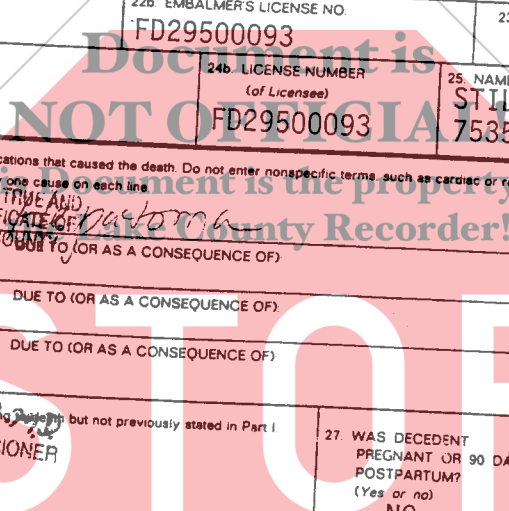
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) TALA NIKOLICH		2 SEX FEMALE	3a TIME OF DEATH 12:30 A.M.	3b DATE OF DEATH (Month, Day, Yr.) MARCH 9, 1999
4 *SOCIAL SECURITY NUMBER 316-58-0260	5a AGE—Last Birthday (Years) 7002	5b UNDER 1 YEAR 042188	5c UNDER 1 DAY 042188	6 DATE OF BIRTH (Mo, Day, Yr.) July 28, 1930
7a WAS DECEDENT A U.S. VETERAN? No	7b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	7 BIRTHPLACE (City and State or Foreign Country) Rotino, Macedonia		
8a FACILITY NAME (If not institution, give street and number) 1546 W. 73rd. Place		9a PLACE OF DEATH (Check only one. See instructions.) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) 1546 W. 73rd. Place	9c CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Jonce Nikolich		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Assembler	
12b KIND OF BUSINESS/INDUSTRY Clothing Factory		13a RESIDENCE—STATE Indiana		
13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Merrillville		13d STREET AND NUMBER 1546 W. 73rd. Place
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? Macedonia	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) _____	
18 FATHER'S NAME (First, Middle, Last) Eftin Stojanovich		19 MOTHER'S NAME (First, Middle, Maiden Surname) Elinka Lalevich		
20a INFORMANT'S NAME (Type/Print) Jonce Nikolich		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1546 W. 73rd. Place Merrillville, IN 46410		20c Relationship Husband
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <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) March 11, 1999 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana
22a EMBALMER'S NAME Richard A. Soria		22b EMBALMER'S LICENSE NO. FD29500093		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Richard A. Soria</i>		24b LICENSE NUMBER (of Licensee) FD29500093		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME STILINOVICH & WIATROLIK FH83004455 7535 Taft St. Merrillville, IN 46410
28. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest. If heart failure, list only one cause on each line. COMPLETE COPY OF THE CERTIFICATE OF DEATH TO BE FILED WITH THE LAKE COUNTY HEALTH DEPT. (OR AS A CONSEQUENCE OF) MAR 10 1999				
b. DUE TO (OR AS A CONSEQUENCE OF) 6 2002				
c. DUE TO (OR AS A CONSEQUENCE OF) 4 months				
PART II. Other significant conditions of illness, injury, or death but not previously stated in Part I. PETER BENJAMIN LAKE COUNTY AUDITOR				
27a WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) NO		27b WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) NO		27c TOPOSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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) as stated.		29b SIGNATURE AND TITLE OF CERTIFIER <i>Alexander S. Williams, M.D.</i>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Sharon Harig, M.D. 8895 Broadway Merrillville, IN 46410		29c MEDICAL LICENSE NO. 01035172	29d DATE SIGNED (Month, Day, Year) 3-10-99	
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>		32 DATE FILED (Month, Day, Year) March 10, 1999		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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 000448		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- jm CAL		



FILED