Key# 36-30-11

29-70-23

* **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. 321

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

APR 22 2002 Franklin J. Premuda MD

Date Issued — Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Edward J. Ostrowski, Jr.
2. SEX: Male
3a. TIME OF DEATH: 9:56P.M.
3b. DATE OF DEATH (Month, Day, Yr.): April 15, 2002
4. *SOCIAL SECURITY NUMBER: 314-26-5909
5a. AGE—Last Birthday (Years): 31
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Nov. 5, 1928
7. BIRTHPLACE (City and State or Foreign Country): Calumet City, IL
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: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Healthcare Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Dolores J. Jerzyk
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Foreman
12b. KIND OF BUSINESS/INDUSTRY: Youngstown (LTV) Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond(Whiting, PO)
13d. STREET AND NUMBER: 1828 Lake Avenue
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: XX 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): ; College (1-4 or 5 +): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): Edward J. Ostrowski, Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Ustach

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mrs. Dolores J. Ostrowski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1828 Lake Ave., Whiting, IN 46394
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 19, 2002 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City, Illinois
22a. EMBALMER'S NAME: Henry J. Blake
22b. EMBALMER'S LICENSE NO.: FDE01019456
23. WAS DEATH REPORTED TO CORONER?: ☐ No XXX Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Martin A. [signature]
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc., FDH83007267 1235-119th St., Whiting, IN 46394

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cerebro Vascular Accident	1 week
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. b. DUE TO (OR AS A CONSEQUENCE OF):	Cardiogenic Shock	
c. DUE TO (OR AS A CONSEQUENCE OF):	Acute Myocardial Infarction	
d. DUE TO (OR AS A CONSEQUENCE OF):	Ischemic Heart Disease	

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): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

CERTIFIER

29a. CERTIFIER (Check only one):
XX 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.: 01048056
29d. DATE SIGNED (Month, Day, Year): Apr/19/02 (April)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. F. Jordan M.D. 761 45th Ave. Ste. 103 Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin J. Premuda M.D.
32. DATE FILED (Month, Day, Year): April 22 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 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.

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SDH06-004 State Form 10110 (R5/1-99)