* **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. 0995-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2002 047938

2002 MAY 23 AM 10:09

MORRIS W. CARTER RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): JOSEPH C. RAJSKI

2 SEX: Male

3a TIME OF DEATH: 8:00 P.M.

3b DATE OF DEATH (Month, Day, Yr.): April 16, 1999

4 *SOCIAL SECURITY NUMBER: 309-03-7222

5a AGE—Last Birthday (Years): 81

5b UNDER 1 YEAR (Months / Days)

5c UNDER 1 DAY (Hours / Minutes)

6 DATE OF BIRTH (Mo. Day, Yr.): March 10, 1918

7 BIRTHPLACE (City and State or Foreign Country): Michigan City, Indiana

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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b FACILITY NAME (If not institution, give street and number): St. Mary Medical Center

9c CITY, TOWN, OR LOCATION OF DEATH: Hobart

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Josephine Sopkowski

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steel worker

12b KIND OF BUSINESS/INDUSTRY: U.S. Steel

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Merrillville

13d STREET AND NUMBER: 637 East 54th Place

13e ZIP CODE: 46410

13f INSIDE CITY LIMITS: [ ] No [X] Yes

13g ON A FARM?: [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY?: U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): John Rajski

19 MOTHER'S NAME (First, Middle, Maiden Surname): Johanna Wildhardt

INFORMANT

20a INFORMANT'S NAME (Type/Print): Josephine Rajski

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 637 E 54th Pl, Merrillville, IN 46410

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Entombment [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 20, 1999 Calvary Cemetery

21c LOCATION—City or Town, State: Portage, Indiana

22a EMBALMER'S NAME: Henry Blake

22b EMBALMER'S LICENSE NO: FD0109406

23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): 1009893

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410

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STOP

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Cerebrovascular accidents.

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

FILED

MAY 23 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

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): --

CERTIFIER

29a CERTIFIER (Check only one):
- [X] 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: Nazzal Obaid, MD

29c MEDICAL LICENSE NO: 01028410

29d DATE SIGNED (Month, Day, Year): 04-19-99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Nazzal Obaid, M.D., 8895 Broadway, Merrillville, IN 46410 (219) 738-2081

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32 DATE FILED (Month, Day, Year): 4-20-99

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

APR 20 1999

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1