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PORTER COUNTY

CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

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MTC

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First, Middle, Last): KATA VOJNOVIC
- 2. SEX: Female
- 3a. TIME OF DEATH: 3:50 AM
- 3b. DATE OF DEATH (Month, Day, Yr): January 13, 1997
- 4. SOCIAL SECURITY NUMBER: 307-74-0472
- 5a. AGE—Last Birthday (Years): 99
- 5b. UNDER 1 YEAR (Months, Days):
- 5c. UNDER 1 DAY (Hours, Minutes):
- 6. DATE OF BIRTH (Mo, Day, Yr): March 13, 1897
- 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 XX Nursing Home ☐ Other (Specify) ☐ Residence
- 9b. FACILITY NAME (If not institution, give street and number): Canterbury Place
- 9c. CITY, TOWN, OR LOCATION OF DEATH: Valparaiso
- 9d. COUNTY OF DEATH: Porter
- 10. MARITAL STATUS (Specify): Widowed
- 11. SURVIVING SPOUSE (If wife, give maiden name): ------
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
- 12b. KIND OF BUSINESS/INDUSTRY: Own Home
- 13a. RESIDENCE—STATE: Indiana
- 13b. COUNTY: Porter
- 13c. CITY, TOWN, OR LOCATION: Valparaiso
- 13d. STREET AND NUMBER: 251 So. Sturdy Road
- 13e. ZIP CODE: 46383
- 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): 4; College (1-4 or 5+):

PARENTS

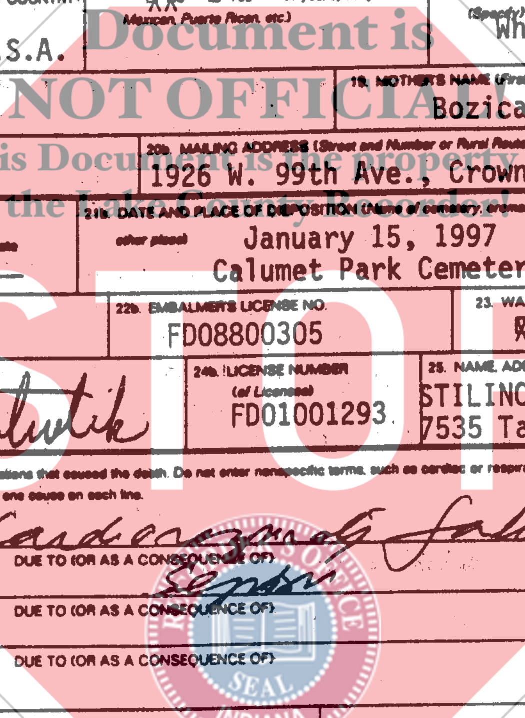
- 18. FATHER'S NAME (First, Middle, Last): Simo Vojnovic
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Bozica Bucan

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Bess Brancic
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1926 W. 99th Ave., Crown Point, IN 46307
- 20c. Relationship: Daughter

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): January 15, 1997 Calumet Park Cemetery
- 21c. LOCATION—City or Town, State: Merrillville, Indiana
- 22a. EMBALMER'S NAME: Leonard Gregorczyk
- 22b. EMBALMER'S LICENSE NO.: FD08800305
- 23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Robert C Wiatrolik
- 24b. LICENSE NUMBER (of Licensee): FD01001293
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: STILINOVICH & WIATROLIK FH83004455 7535 Taft St., Merrillville, IN 46410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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.	Cardiorespiratory failure	Minutes
DUE TO (OR AS A CONSEQUENCE OF) b.	Sepsis	Days
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

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): 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: 01037891
- 29d. DATE SIGNED (Month, Day, Year): 1-14-97
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. NAZEAN MD 404 10TH ST Dyer IN 46310

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Gary A. Babinec
- FILED
- 32. DATE FILED (Month, Day, Year): January 14, 1997
- 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: NOV 26 2002
- 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): PETER BENJAMIN LAKE COUNTY AUDITOR
- 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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