

0445031240

Ky No. 34-99-1

INDIANA STATE BOARD OF HEALTH

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

Local No. 226

CERTIFICATE OF DEATH

May 20, 2005 Date Issued Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) WALTER C. ZWIJAC		2 SEX MALE	3a TIME OF DEATH 11.15 P.M.	3b DATE OF DEATH (Month, Day, Yr) MARCH 22, 1991	
4 SOCIAL SECURITY NUMBER 327 16 0146	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) June 23, 1920	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois	8a WAS DECEDENT A U.S. VETERAN? Yes				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) XXXX Residence			
9b FACILITY NAME (If not institution, give street and number) 7046 Birch Ave.		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) Sara (Wandel)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Self Employed		12b KIND OF BUSINESS/INDUSTRY S & W Service Station	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond		13d STREET AND NUMBER 7046 Birch Ave	
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 years		College (1-4 or 5+) 2 years			
18 FATHER'S NAME (First, Middle, Last) Andrew Zwi jac		19 MOTHER'S NAME (First, Middle, Maiden Surname) Katherina Guzy			
20a INFORMANT'S NAME (Type/Print) Sara Zwi jac		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7046 Birch Ave. Hammond, Indiana 46324		20c Relationship Wife	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <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 26, 1991 Holy Cross Cemetery		21c LOCATION—City or Town, State Calumet City, Illinois	
22a EMBALMER'S NAME Charles W. Wells		22b EMBALMER'S LICENSE NO. 1042372	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony Solan</i>		24b LICENSE NUMBER (of Licensee) FD# 1051840	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN FUNERAL HOME PH# 3002893 7109 Calumet Ave., Hammond, Ind. 46324		
26 PART I. Enter the disease(s), 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 Basal Cell Carcinoma			
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b _____			
		c _____			
		d _____			
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) ---		
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) and manner as stated.					
29b SIGNATURE AND TITLE OF CERTIFIER <i>Raymond Hohl M.D.</i>		29c MEDICAL LICENSE NO. 003-036-071348-1	29d DATE SIGNED (Month, Day, Year) March 25, 1991		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Raymond Hohl M.D. 5841 South Maryland Chicago, Illinois 60637					
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>			32 DATE FILED (Month, Day, Year) MAR. 25 1991		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED 00622
		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) 9- LA	
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

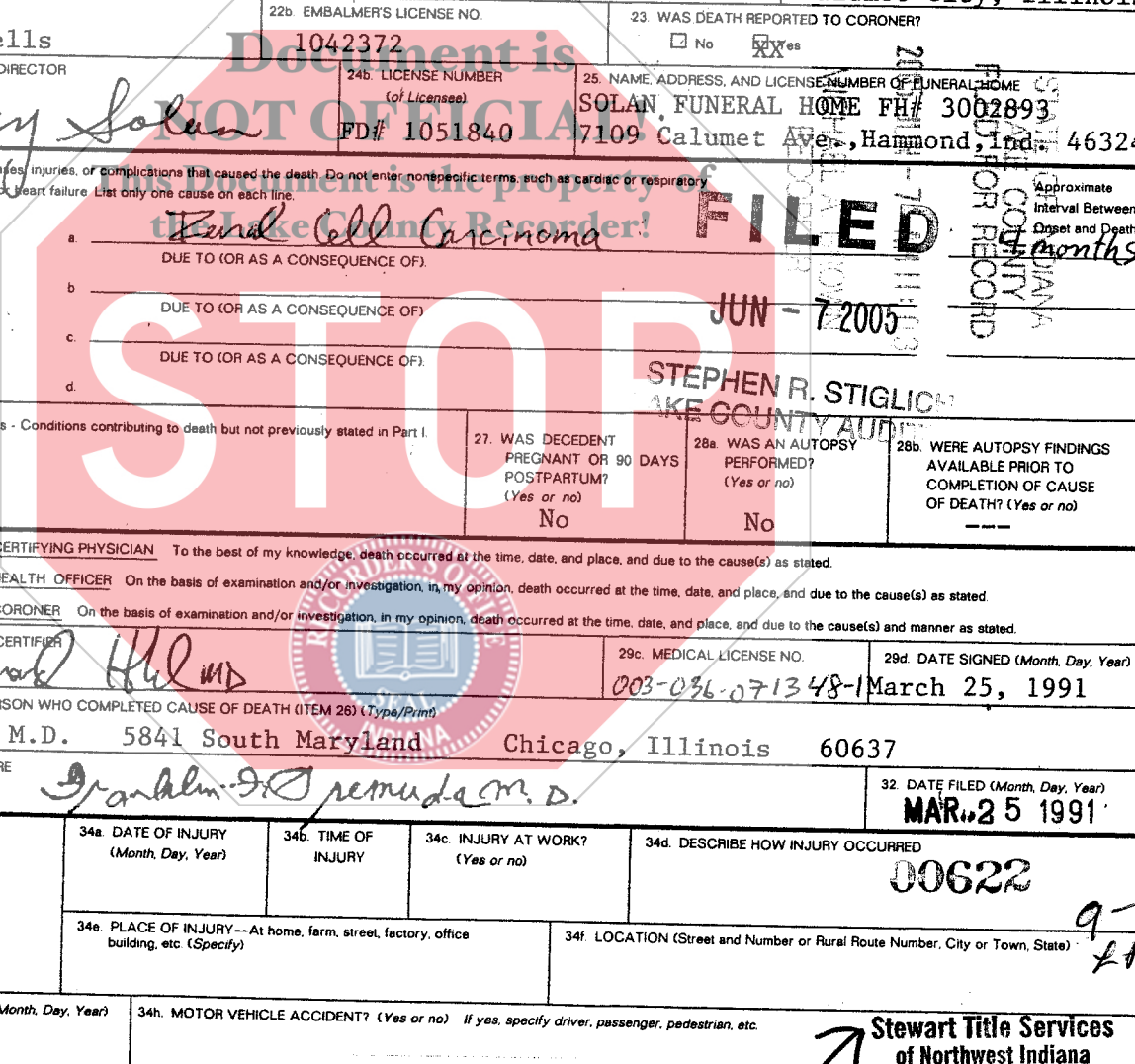
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER

SE ONLY



SBH06-004

State Form 10110 (R2/3-89)

DEA CERT/PO 1

Stewart Title Services
of Northwest Indiana
The Pointe
5521 W. Lincoln Hwy.
Crown Point, IN 46307

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SJS