

* ATTENTION: STATE: 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

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

Local No. 917

CERTIFICATE OF DEATH

Nov. 17, 2000
Date Issued
Hammond Health Commission

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) STANLEY A. SKURA, SR.		2 SEX MALE	3a TIME OF DEATH 7:05 P M	3b DATE OF DEATH (Month, Day, Yr) NOVEMBER 16, 2000
4 *SOCIAL SECURITY NUMBER 313-14-0810	5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) OCT. 24, 1923
7 BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA	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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) ST. MARGARET MERCY HOSPITAL		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) CHRISTINE PIERZCHALSKI	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) BRICKLAYER		12b KIND OF BUSINESS/INDUSTRY CONSTRUCTION
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION HAMMOND		13d STREET AND NUMBER 419 GOSTLIN STREET
13e ZIP CODE 46327	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? USA	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 College (1, 4 or 5+) 			18 FATHER'S NAME (First, Middle, Last) STANLEY SKURA	
19 MOTHER'S NAME (First, Middle, Maiden Surname) ANTOINETTE KOT			20a INFORMANT'S NAME (Type/Print) CHRISTINE SKURA	
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 GOSTLIN STREET, HAMMOND, INDIANA 46327			20c Relationship WIFE	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) NOVEMBER 20, 2000 ST. JOSEPH CEMETERY		21c LOCATION—City or Town, State HAMMOND, INDIANA
22a EMBALMER'S NAME KEITH D. ANTHONY		22b EMBALMER'S LICENSE NO. 01011911	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D Anthony</i>		24b LICENSE NUMBER (of Licensee) 01011911	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327	
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. Respiratory failure Liver failure Septicemia due to Staphylococcus Aureus				Approximate Interval Between Onset and Death
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Chronic Renal Insufficiency				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		
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>K. Patel</i>			29c MEDICAL LICENSE NO. 01043474	29d DATE SIGNED (Month, Day, Year) NOVEMBER 17, 2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) KANTILAL PATEL M.D. 529 W. CHICAGO STREET, EAST CHICAGO, INDIANA 46312				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Sremuda M.D.</i>				32 DATE FILED (Month, Day, Year) November 17, 2000
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		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.		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

