

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 0773-03

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) NIKOLA VASICH		2. SEX MALE		3. TIME OF DEATH 10:47 A		3a. DATE OF DEATH (Month, Day, Yr) NOVEMBER 19, 2003	
4. SOCIAL SECURITY NUMBER 314-44-9921		5a. AGE—Last Birthday (Years) 63		5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 DAY Hours: _____ Minutes: _____	
6. DATE OF BIRTH (Mo, Day, Yr) JAN. 15, 1940		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? NONE		9a. PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) WILLIAM J. RILEY HOSPICE CENTER				9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) DESA		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) STEELWORKER		12b. KIND OF BUSINESS/INDUSTRY INLAND STEEL COMPANY	
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION SCHERERVILLE		13d. STREET AND NUMBER 442 SUMMER DR.	
13e. ZIP CODE 46375		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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 College (1-4 or 5+) _____					
18. FATHER'S NAME (First, Middle, Last) DUSAN VASIC				19. MOTHER'S NAME (First, Middle, Maiden Surname) MILICA PLAVSIC			
20a. INFORMANT'S NAME (Type/Print) DESA VASICH				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 442 SUMMER DR. SCHERERVILLE, IN. 46375		20c. Relationship WIFE	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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 22, 2003 CALUMET PARK CEMETERY		21c. LOCATION—City or Town, State MERRILLVILLE, INDIANA	
22a. EMBALMER'S NAME ELI VUJKO		22b. EMBALMER'S LICENSE NO. FDO1008300		23. WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER FDO1008300		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307			
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. BRADEN CANCER							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF)							
b. DUE TO (OR AS A CONSEQUENCE OF)							
c. DUE TO (OR AS A CONSEQUENCE OF)							
d. DUE TO (OR AS A CONSEQUENCE OF)							
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I HYPERTENSION / DM							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) _____							
28a. WAS AN AUTOPSY PERFORMED? (Yes or 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>[Signature]</i>						29c. MEDICAL LICENSE NO. 230001086	
29d. DATE SIGNED (Month, Day, Year) 11-24-03							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 3100 Highland St. Highland IN 46322 STEVEN CORSE MD							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) November 25, 2003	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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)		015616			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

Parcel # 20-13-180-2

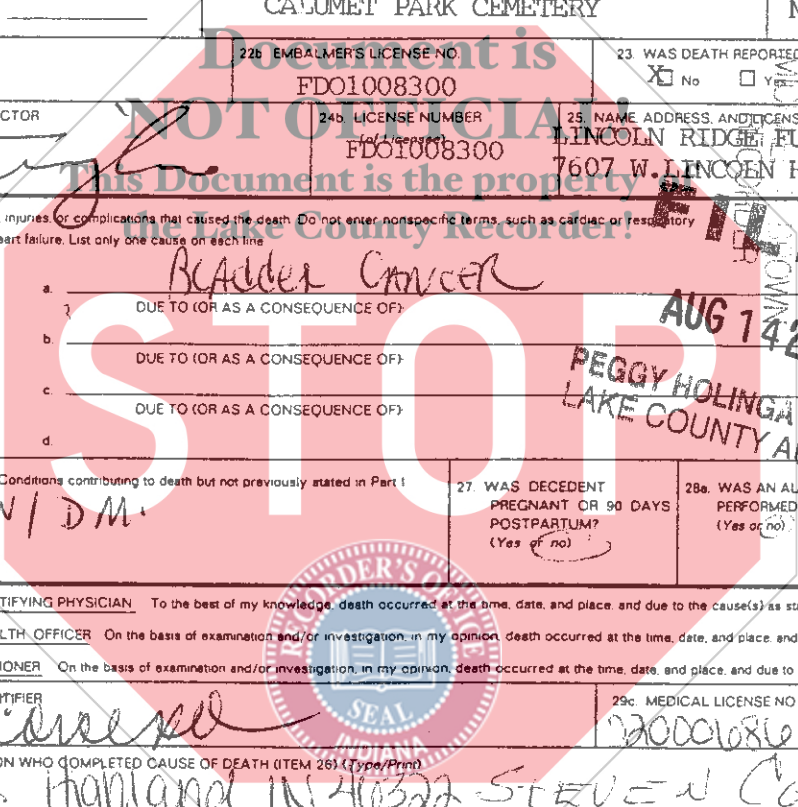
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



FILED
AUG 14 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR