1 10cc + Vets

INDIANA STATE BOARD OF HEALTH

Key #45-178-7

Local No. 3892-89

CERTIFICATE OF DEATH

State No. 2005

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME	FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Mo., Day, Yr.)
	JOHN	S.	BODNAR	MALE	AUGUST 2, 1989

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
306-09-5457	72			DEC 27 1916	Fairmont, West Virginia

8. 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)
1945		

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Methodist Hospital Southlake	Merrillville	Lake

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
Married	Mary Bianco	Steel Worker	U.S. Steel

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Gary	111 W. 47th Avenue

13e. INSIDE CITY LIMITS? (Yes or no)	13f. FARM	13g. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: [X] No [ ] Yes	15. RACE—American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
Yes	No	46408		White	8th

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles Bodnar	Barbara Chalky

INFORMANT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c. RELATIONSHIP
Mary Bodnar	111 W 47th Avenue, Gary, IN 46408	Wife

DISPOSITION

20a. METHOD OF DISPOSITION	20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	August 5, 1989 Calumet Park Cemetery	Merrillville, IN

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (of Licensee)	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Robert Wiatrolik	FD01001293	Stilinovich & Wiatrolik FH3004455 7535 Taft, Merrillville, IN 46410

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death	23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title	23b. LICENSE NUMBER	23c. DATE SIGNED (Month, Day, Year)

24. TIME OF DEATH	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
1:04 PM	August 2, 1989	NO

CAUSE OF DEATH

SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Ischemic Cardiomyopathy — DUE TO (OR AS A CONSEQUENCE OF): — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Kidney Disease, Hypertension

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	

SEE INSTRUCTIONS

CERTIFIER

28c. CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed items 23a-c) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

28d. SIGNATURE AND TITLE OF CERTIFIER	28e. DATE SIGNED (Month, Day, Year)

FILED
AUG 15 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type/Print)
Dr. Ashbach

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE

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

DEC 7 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)

JAN 2 7 2006

SBH06-004 State Form 10110 Rev. 10/87 DEATH/FD 1

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