* 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.

peing requested by	ATE: The Social Security this state agency in ordy responsibility. Disclosi	der to IND	IANA S	TATE DEPA	ARTME	NT OF	HEA	ALTH A							
oluntary and there	will be no penalty for ref	usal.	C	ERTIFICAT	RTIFICATE OF DEATH State No										
200ai 110	THE RECORDS IN THIS	SERIES ARE CO	NFIDENTIAL PE	ER IC 16-37-1-10											
YPE/PRINT	1 DECEASED-NAME (Fire	DECEASED—NAME (First Middle, Last)						2. SEX 3a. TIME OF DEA							
IN	Emilia	Sawchik	:/ U4	0000		Fema		9:50a		16					
ERMANENT	4. *SOCIAL SECURITY NUMBER	*SOCIAL SECURITY NUMBER Sa AGE—Last Birthday (Years)				D. Harris Ministra				TE OF BIRTH (Mo. Day 10) 7. BIRTHPLACE (City and State or Foreign Country)					
BLACK INK	310 38 514		" 96	Months Days	Mar 15 1909 Poland										
	8a. WAS DECEDENT	8b. YEAR LAST	SERVED IN			9a PÚ	ACE OF DEATH (Check only one See instructions)								
	A U.S. VETERAN?	US. ARMED	T ONOLS!	HOSPITAL Inpatient		OTHER: Nursing H			me Other (Specify)						
	No	N/A	N/A		☐ ER/Outpatient ☐		(NL OR LOC	R LOCATION OF DEATH		9d COUNTY OF DEATH					
DECEDENT	9b. FACILITY NAME (If not institution, give street and number)							_							
SECESEIV.	5026 Magoun Ave					East Chicago S USUAL OCCUPATION (Give kind of work			Lake						
	10. MARITAL STATUS (Specify) 11. SURVIVING SPOUSE (If wife, give maiden, name)			done during most of			vorking life. Do not use retired)			·					
	Widow N/I		N/A			<u>emaker</u>				Own Home			—		
	138. RESIDENCE—STATE	38. RESIDENCE—STATE 136 COUNTY		13c. CITY, TOWN, OR	13d. STREET AND				•						
	Indiana	Indiana Lake		East Ch	5026 Mag			oun 1	lγe			_			
	13e. ZIP CODE 13f. INSIDE		CITIZEN OF VHAT COUNTRY			OF HISPANIC ORIGIN? es (If yes, specify Cuban.		16. RACE—American Indian, Black, White, etc.		17. DECEDENT'S E (Specify only highest g					
	□ No Ø Yes WHAT COUNTRY?			Mexican, Puerto F	. ,	(Specify)		Elementary	Secondary ()-12)	College (1-4 or 5	+)			
	46212		JSA				W1	hite		L2					
7	18. FATHER'S NAME (First M	U Tes I		<u> </u>		19. MOTHER	S NAME (First, Middle, Maiden	Surname)						
PARENTS 1															
ــــــــــــــــــــــــــــــــــــــ	20s INFORMANT'S NAME (T	ype/Print)		20b MAILING	G ADDRESS (S	treet and Number	r or Rural R	oute Number, City or	Town, State, 2	(ip Code)	20c Rel	ationship			
NFORMANT Z	Jeanie Sza	9542	9542 Dogwood Dr Munster I					n 46321 Daughter							
7	21a METHOD OF DISPOSITION	21b. DATE AND PLAC				21c LOCATI	ON-City or	Town, Sta	nte						
1	Burial ☐ Crematic	other place)	Sep 2	;											
, N	☐ Donation ☐ Other (S	1	Holv Ghost Cemeter				1			nd In					
	22a. EMBALMER'S NAME:		4/	225. EMBALMER'S LICENSE NO 23. WAS DEATH REPORTED TO CORONER?											
DISPOSITION	James W G	nolaton			4194	L 15		■ No □ Y	es						
	248. SIGNATURE OF FUNERA		NIC		ICENSE NUMB			ADDRESS, AND LIC			AL HOM	E			
;	101		110		(of Licensee)			iak FH8	3001	501					
\circ	Jelm B	Nan III	nia Ph	cument	00549	hron	1918	Magoun	E C	nicae	50]	[n 463]	12		
7	Approximate														
· **/	arrest, shock, or heart failure. List only one cause on each line.														
4	Onset and Death												łh		
<i>K</i>	IMMEDIATE CAUSE (Final disease or condition	a 🖊	DUE TO	OR AS A CONSEQUENCE	CE OF)			4							
CAUSE OF	resulting in death)	h d					Ma	7 68	?						
DEATH	Conditions, if any, which gave		DUE TO	OR AS A CONSEQUEN	CE OF)		790								
#	rise to the immediate cause. stating the underlying	c. 💆	2115 70	20.10.1001050151	4 OF)	44 Gr		9 20			····-				
•	cause last		DOE 10 (OR AS A CONSEQUENT	JE OFF	\$ C	YO,	(D)							
_		d.			-	ARE CO	VA A	G a	-	$\overline{}$					
9	PART II. Other significant cond	but not previously stated	in Part I	27. WAS DECE	OR 90 DAYS A PERFORM		AUTOPSY								
\supset	Azlemen					JM7 4 (D) (cg, or no)		COMPLETION OF CAUSE OF DEATH? (Yes or no) NO							
رح	•	THE													
\bigcap				(0.00)	W 2 CV	No				_ l	14.0	····	—		
(_ 				best of my knowledge, de						a aassa (-)	etate d				
	one)	HEALTH OFFICE	On the basis of	examination and/or inves	stigation, in my o	pinion, death occ	t the time	time, date, and place				ard			

CERTIFIER

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Peint) James Walsh MD 5500 Hohman Ave Hammond Burn Borrow

TIME OF 34c INJURY AT WORK?
N.IURY (Yes or no) 34b TIME OF 34d. DESCRIBE HOW INJURY OCCURRED 34a. DATE OF INJURY 33 MANNER OF DEATH Natural Pending Investigation 1
34e. PLACE OF INJURY—At home farm street, factory, office building, etc. (Specify) Accident 34f LOCATION (Street and Number or Rural Could not be Determined Suicide 003295 34g DATE PRONOUNCED DEAD (Month, Day, Year) 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

(5/0**\$**DH06-004 State Form 10110 (R5/1-99)

31 HEALTH OFFICER'S SIGNATURE

29c. MEDICAL LICENSE NO. 0/027487