

* 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. 0359-97

26-34-0335-0011

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) MIKE WINARSKI		2. SEX MALE	3a. TIME OF DEATH 2:10 P.M.	3b. DATE OF DEATH (Month, Day, Yr.) FEBRUARY 12, 1997	
4. *SOCIAL SECURITY NUMBER 357-07-8418	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.) June 5, 1919	
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana		8a. WAS DECEDENT A U.S. VETERAN? yes			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" 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) THE COMMUNITY HOSPITAL		9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) married	11. SURVIVING SPOUSE (If wife, give maiden name) Kathleen Pridavok	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steel Manufacturing		12b. KIND OF BUSINESS/INDUSTRY Steel production	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond		
13d. STREET AND NUMBER 7029 Osborn Street		13e. ZIP CODE 46323			
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) 8 College (1-4 or 5+) 2001	
18. FATHER'S NAME (First, Middle, Last) Domitrio Winarski		19. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Lechinski			
20a. INFORMANT'S NAME (Type/Print) Kathleen Winarski		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7029 Osborn Street, Hammond Indiana 46323		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) February 15, 1997 Catholic Cemeteries		21c. LOCATION—City or Town, State Hammond, Indiana	
22a. EMBALMER'S NAME Ronald Reed		22b. EMBALMER'S LICENSE NO. FDO1001081		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FDO101451		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Road Highland, Indiana 46322 FH83007500	
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. MYOCARDIAL INFARCTION		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) n/a		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. 01029300		29d. DATE SIGNED (Month, Day, Year) FEBRUARY 13, 1997	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) NITIN SARDESAI, M.D. 9307 CALUMET AVENUE MUNSTER, INDIANA 46321					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) February 14, 1997	
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) 11-19-96	34b. TIME OF INJURY JUN 04 2007	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED FILED
34e. PLACE OF INJURY—At home, farm, street, factory, office PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		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.			