152041

City Of East Chicago
East Chicago, In 46312

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.

Local No. 292

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	ERNEST D. BAYUS
2. SEX	MALE
3a. TIME OF DEATH	12:35P.M.
3b. DATE OF DEATH (Month, Day, Yr.)	DECEMBER 6, 2006
4. *SOCIAL SECURITY NUMBER	305-30-9896
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.)	JAN. 4, 1929
7. BIRTHPLACE (City and State or Foreign Country)	WHITING, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?	YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1953
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: XX Inpatient; ☐ ER/Outpatient; ☐ DOA. OTHER: ☐ Nursing Home; ☐ Residence; ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST. CATHERINE HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH	EAST CHICAGO
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	LEE (UNKNOWN)
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	INSPECTOR
12b. KIND OF BUSINESS/INDUSTRY	U.S. GOVERNMENT
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HAMMOND(WHITING P.O.)
13d. STREET AND NUMBER	967 REESE AVENUE
13e. ZIP CODE	46394
13f. INSIDE CITY LIMITS	XX No ☐ Yes
13g. ON A FARM?	XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	College: 2

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	PAUL BAYUSZ
19. MOTHER'S NAME (First, Middle, Maiden Surname)	ANNA TOTH

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	MRS. PATRICIA ENRIGHT
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4306 TOWLE AVE., HAMMOND, IN 46327
20c. Relationship	NIECE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	XX Burial; ☐ Cremation; ☐ Removal from State; ☐ Entombment; ☐ Donation; ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	DECEMBER 12, 2006 ST. JOHN CEMETERY
21c. LOCATION—City or Town, State	HAMMOND, INDIANA
22a. EMBALMER'S NAME	HENRY J. BLAKE
22b. EMBALMER'S LICENSE NO.	FDE01019406
23. WAS DEATH REPORTED TO CORONER?	XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. MULTIORGAN FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

b. COCCAINE ABUSE

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A

28a. AUTOPSY PERFORMED? (Yes or no) NO

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A

CERTIFIER

29a. CERTIFIER (Check only one)

XX CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated.

☐ 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.

☐ 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	01045012
29d. DATE SIGNED (Month, Day, Year)	DEC. 8, 2006
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	M.C. MANGAHAS, M.D., 521 W. CHICAGO AVENUE, EAST CHICAGO, IN 46312

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] MD
32. DATE FILED (Month/Day, Year)	12/8/06

Field	Entry
33. MANNER OF DEATH	☐ Natural; ☐ Pending Investigation; ☐ Accident; ☐ Suicide; ☐ Could not be Determined; ☐ 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.	

024514

$11 ck# 627934 CN

FILED DEC 06 2007

IVRA 30 (7/05)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT