

\* 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. 0545-99

#203014

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

BT 900449

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

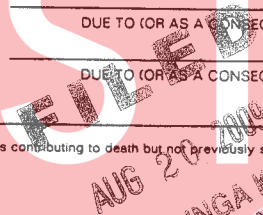
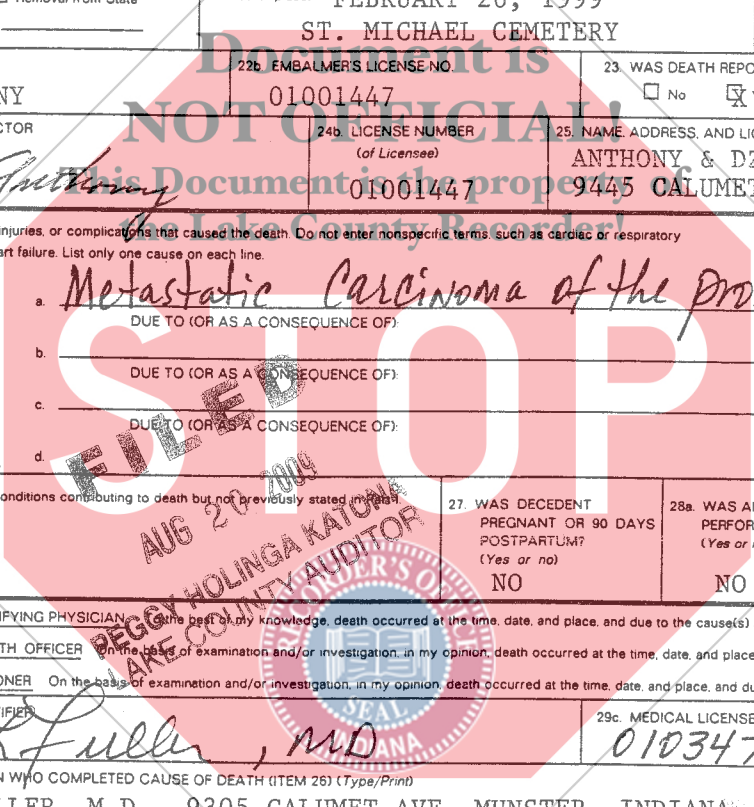
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) EDWIN LOUIS JAROSZ				2. SEX MALE		3a. TIME OF DEATH 7:50 P.M.		3b. DATE OF DEATH (Month, Day, Yr.) FEBRUARY 22, 1999					
4. SOCIAL SECURITY NUMBER -4692		5a. AGE—Last Birthday (Years) 73		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) OCT. 28, 1925		7. BIRTHPLACE (City and State or Foreign Country) CALUMET CITY, ILLINOIS			
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 type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)									
9b. FACILITY NAME (If not institution, give street and number) 9619 CRESTWOOD AVENUE				9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER				9d. COUNTY OF DEATH LAKE					
10. MARITAL STATUS (Specify) WIDOWED		11. SURVIVING SPOUSE (If wife, give maiden name) NONE		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) POSTAL CLERK				12b. KIND OF BUSINESS/INDUSTRY U.S. POST OFFICE					
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION MUNSTER				13d. STREET AND NUMBER 9619 CRESTWOOD AVENUE					
13a. ZIP CODE 46321		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) College (1-4 or 5+)			
18. FATHER'S NAME (First, Middle, Last) LOUIS JAROSZ						19. MOTHER'S NAME (First, Middle, Maiden Surname) ANTOINETTE MENDYK							
20a. INFORMANT'S NAME (Type/Print) EDWIN R. JAROSZ				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702-170TH PLACE, HAMMOND, IN 46324				20c. Relationship SON					
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 26, 1999 ST. MICHAEL CEMETERY				21c. LOCATION—City or Town, State HAMMOND, INDIANA					
22a. EMBALMER'S NAME LARRY D. ANTHONY				22b. EMBALMER'S LICENSE NO. 01001447		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>				24b. LICENSE NUMBER (of Licensee) 01001447		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ F.H. #83002916 9445 CALUMET AVE, MUNSTER, IN 46321							
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Metastatic Carcinoma of the prostate</i> DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last													
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) 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) NO					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN On the basis 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>Barbara L. Fuller, MD</i>						29c. MEDICAL LICENSE NO. 01034701		29d. DATE SIGNED (Month, Day, Year) 3/2/99					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) BARBARA L. FULLER, M.D. 9305 CALUMET AVE, MUNSTER, INDIANA 46321													
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Skilina MD</i>						32. DATE FILED (Month, Day, Year) March 3, 1999							
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)		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. 004006									



Vertical stamp: MICHAEL A. BROWN, RECORDER, LAKE COUNTY, INDIANA, 2009 FEB 21 AM 9:00

Handwritten circled number 2

Handwritten #11

Handwritten CA