87-033155

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

Local No. 1533-87

State No.

EMBALMER'S NAME PETER N. MORIKIS LICENSE No. FDE 8600652

FUNERAL DIRECTOR'S SIGNATURE [signature] FUNERAL DIRECTOR'S LICENSE No. FDE 1041083 FUNERAL HOME No. FDH3003069

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

1 DECEASED—NAME (First, Middle, Last): STELLA R. CHIRILA

2 SEX: F

3 DATE OF DEATH (Month, Day, Year): AUGUST 17, 1987

4 RACE (e.g. White, Black, American Indian, etc.) (Specify): WHITE

5a AGE (Last Birthday) (Years): 66

5b UNDER 1 YEAR (Months / Days):

5c UNDER 1 DAY (Hours / Mins):

6 DATE OF BIRTH (Mo., Day, Yr.): 7-29-1921

7a COUNTY OF DEATH: LAKE

7b CITY, TOWN OR LOCATION OF DEATH: HOBART

7c HOSPITAL OR OTHER INSTITUTION (Name; if not in either, give street and number): ST. MARY MEDICAL CENTER

7d IF HOSP. OR INST. (Indicate DOA or Emer. Rm. Inpatient) (Specify): INPATIENT

8 STATE OF BIRTH (If not in U.S.A. name country): INDIANA

9 CITIZEN OF WHAT COUNTRY: USA

10 MARRIED (NEVER MARRIED / MARRIED / WIDOWED / DIVORCED) (Specify): MARRIED

11 SURVIVING SPOUSE (If wife, give maiden name): JOHN CHIRILA

12 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No): NO

13 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 14a HOMEMAKER

14b KIND OF BUSINESS OR INDUSTRY: N/A

USUAL RESIDENCE WHERE DECEASED LIVED (IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

15a RESIDENCE—STATE: INDIANA

15b COUNTY: LAKE

15c CITY, TOWN OR LOCATION: HOBART

15d STREET AND NUMBER: 3109 W. RIDGE ROAD

15e IS RESIDENCE ON A FARM? YES ☐ NO ☒

15f INSIDE CITY LIMITS (SPECIFY YES OR NO): YES

15g IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES ☐ NO ☒

PARENTS

16 FATHER—NAME (First, Middle, Last): ADAM KALCZYNSKI

17 MOTHER—MAIDEN NAME (First, Middle, Last): JULIA KACZMARCZYK

18a INFORMANT—NAME (Type or print) RELATIONSHIP: JOHN CHIRILA HUSBAND

18b MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip): 3109 W. RIDGE ROAD HOBART INDIANA 46342

DISPOSITION

19a BURIAL, CREMATION, REMOVAL, OTHER (Specify): CREMATION

19b CEMETERY OR CREMATORY—FUNERAL HOME: CALVARY CREMATORY

19c LOCATION (City or Town, State): PORTAGE, INDIANA

20a DATE (Month, Day, Year): AUGUST 21, 1987

20b FUNERAL HOME—NAME AND ADDRESS (Street or R.F.D. No., City or Town, State, Zip): REES FUNERAL HOME, 600 W. RIDGE ROAD, HOBART, IN

M.D. OR D.O.

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

21a Signature: [signature]

21b DATE SIGNED (Mo., Day, Yr.): 8-19-87

21c HOUR OF DEATH: 5:20 PM

NAME OF ATTENDING PHYSICIAN (Type or Print): 21d DR. R. L. BILLENA, JR., M.D.

MAILING ADDRESS—PHYSICIAN: 21e 5490 BROADWAY, MERRILLVILLE, INDIANA 46410

22a HEALTH OFFICER—SIGNATURE: [signature]

22b DATE RECEIVED BY LOCAL HEALTH OFFICER: 8-20-87

CAUSE

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE (STATING THE UNDERLYING CAUSE LAST)

23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)

PART I (a) Cardio-respiratory arrest — Interval between onset and death:

DUE TO OR AS A CONSEQUENCE OF

(b) Stroke — Interval between onset and death:

DUE TO OR AS A CONSEQUENCE OF

(c) — Interval between onset and death:

PART II OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to cause given in PART I(a)): CA Resp Pneumonia

AUTOPSY (Specify Yes or No): 24 NO

SBH 06-003 State Form 35430
REV 10/77