

NON-RESIDENT

INDIANA STATE BOARD OF HEALTH
Division of Vital Records
CERTIFICATE OF DEATH

Local No. **331**
Death No. **35563**

1. PLACE OF DEATH a. COUNTY LaPorte 246		2. USUAL RESIDENCE (When deceased lived, if different, address before admission) a. TOWN Indiana b. COUNTY Lake	
b. CITY (If outside corporate limits, give RURAL) Michigan City Ind.		c. CITY (If outside corporate limits, write RURAL) Gary 145	
d. FULL NAME OF HOSPITAL OR INSTITUTION Warren Hospital 586		d. STREET ADDRESS (If rural, give location) 2228 Washington St.	
2. NAME OF DECEASED a. (First) Peter		b. (Middle) Stritof	
c. (Last)		4. DATE (Month) (Day) (Year) OF DEATH May 4th 1953	
3. SEX Male	5. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 12, 1880
9. AGE (In years) 73		10. USUAL OCCUPATION (When deceased was at work, give date during most of working life, even if transient) Retired	
10. KIND OF BUSINESS OR INDUSTRY Real Estate Salesman		11. BIRTHPLACE (State or foreign country) Jugoslavia	
12. FATHER'S NAME Unknown		14. MOTHER'S MARRIAGE NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT (NAME AND ADDRESS) Lusy Stritof 2228 Washington St.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 wks
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Mention conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. Diabetes mellitus		
	2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. ACCIDENT (Specify) Slip	21b. PLACE OF INJURY (e.g., household, farm, factory, street, other building, etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at <input type="checkbox"/> Home <input type="checkbox"/> Not While at Home <input type="checkbox"/> Work <input type="checkbox"/> at Work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22a. ATTENDING PHYSICIAN: I certify that I attended the deceased from 10/22 10:12 AM to 2004 , and that death occurred at 9:27 AM from causes stated and on above date.	22b. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at 9:27 AM from causes stated and on above date.
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23a. Signature of Attending Physician or Health Officer. Brian Potter MD	23b. ADDRESS Michigan City, Indiana	23c. DATE SIGNED 11/5/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/7/53	24c. NAME OF CEMETERY OR CREMATORY Calumet Park Cem.	24d. LOCATION Crown Point Ind.
DATE REC'D BY LOCAL HEALTH OFFICER 11-5-53	SIGNATURE OF HEALTH OFFICER W. J. Conner MD	25. FUNERAL DIRECTOR Lech & Stilnevich Gary Ind.	ADDRESS