Local No. 4284-89

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. 89-037067

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
DONALD R. TURCHANY	Male	12:35 A.M.	October 4, 1989

4. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
47			Sept.22, 1942	Chicago, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
Yes	— — —	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
3116 W. 40th Avenue	Hobart	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Janice Chirila	Self-Employed	Pioneer Lock Service

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	3116 W. 40th Avenue

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46342	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Steven A. Turchany	Dora Sobal

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Janice Turchany	3116 W. 40th Ave., Hobart, IN 46342	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	October 6, 1989 Calvary Cemetery	Portage, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James W. Gholston	FD01004194	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Donald L. Rees	FD01041083	Rees Funeral Home FH3003069 600 W.Old Ridge Rd.,Hobart, IN 46342

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 Gunshot wound to head & brain	Unknown
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b	
	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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	Yes	Yes

CERTIFIER

29a. CERTIFIER (Check only one)

- ☐ 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

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Daniel D. Thomas M.D.	16120	Oct. 5, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Earl A. Johnson	Oct. 5, 1989

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☒ Suicide ☐ Could not be Determined ☐ Homicide	Unknown	Unknown	No	Gunshot wound

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)
Home	3116 W. 40th Ave.,Hobart, IN

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
October 4, 1989	N/A