Local No. 103875 90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): BETTY IRENE ADAMCZYK
2. SEX: FEMALE
3a. TIME OF DEATH: 2:45 PM
3b. DATE OF DEATH (Month, Day, Yr.): MAY 25, 1990
4. SOCIAL SECURITY NUMBER: 397-18-5809
5a. AGE—Last Birthday (Years): 66
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): NOV. 3, 1923
7. BIRTHPLACE (City and State or Foreign Country): LADIESSMITH, WISC.
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 8628 LEE ST.
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CHESTER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOME MAKER
12b. KIND OF BUSINESS/INDUSTRY: HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 8628 LEE ST.
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS? ☐ No ☐ Yes
13g. ON A FARM? ☐ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): WILLIAM TINDER
19. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA JORDAN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CHESTER ADAMCZYK
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8628 LEE ST. CROWN POINT, INDIANA 46307
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 30, 1990 CHAPEL LAWN CEM.
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: CHARLES WELLS
22b. EMBALMER'S LICENSE NO.: 4237
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Eli Taylor
24b. LICENSE NUMBER (of Licensee): 1008300
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE F.H. 7607 W. LINCOLN HWY. CROWN POINT, IND. 88800070

CAUSE OF DEATH

26. PART I. Enter the disease, 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. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Senile dementia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: a. 1 hr. b. 3-5 yrs. c. 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 related to the above:

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)

MAY 31 1990

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: LAKE COUNTY HEALTH COMMISSIONER
29c. MEDICAL LICENSE NO.: 01029166
29d. DATE SIGNED (Month, Day, Year): 5/30/90

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): HAKAM SAFADI, M.D. 8695 CONNECTICUT ST., MERRILLVILLE, IN. 46410
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): May 31, 90

CORONER USE ONLY

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.

FILED
JUN 04 1990

Schererville Heights Sec No 1, 1.43, B.2 unit 9 Key #11-110-14

SBH06-004 State Form 10110 (R2/3-89) DEA

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