THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

APR. 30, 1991 — Date Issued — Hammond Health Commissioner

9102100 INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 320 unit #26

Calumet Center Add L.13, Bl.3; Key#32-105-13

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Pauline Winkler
2 SEX: Female
3a TIME OF DEATH: 3:04 A M
3b DATE OF DEATH (Month, Day, Yr): April 28, 1991
4 SOCIAL SECURITY NUMBER: 310-22-9242
5a AGE—Last Birthday (Years): 81
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo, Day, Yr): Nov. 14, 1909
7 BIRTHPLACE (City and State or Foreign Country): Grant Park, IL
8a WAS DECEDENT A US VETERAN? No
8b YEAR LAST SERVED IN US ARMED FORCES? No
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Widow
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): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Home
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 821 River Dr.
13e ZIP CODE: 46324
13f INSIDE CITY LIMITS: [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY? U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 9; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): August Blank
19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Poppe

INFORMANT

20a INFORMANT'S NAME (Type/Print): Shirley Wilson
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7141 Schneider St. Hammond, IN 46323
20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Sp...) [ ] Entombment [ ] Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 1, 1991 Concordia Cemetery
21c LOCATION—City or Town, State: Hammond, IN
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO.: 1045964
23 WAS DEATH REPORTED TO CORONER? [ ] No [ ] Yes XX
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b LICENSE NUMBER (of Licensee): 1045184
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster, In 46321

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiomyopathy — Approximate Interval Between Onset and Death: unknown
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)

FILED MAY 51 PM '91 ROBERT ... FREELAND RECORDER — LAKE COUNTY INDIANA/S.S.

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: Frank Hieber
29c MEDICAL LICENSE NO.: 19344
29d DATE SIGNED (Month, Day, Year): April 30, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. F. Hieber 7550 Hohman Avenue Munster- Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin ... M.D.
32 DATE FILED (Month, Day, Year): APRIL 30, 1991

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 MAY 2 1991

Anna N. Anton — AUDITOR LAKE COUNTY

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1 00142

7141 Schneider, Hammond, IN 46323

6.00