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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0530-93 State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): ESTHER J. RYGIEL

2 SEX: FEMALE

3a TIME OF DEATH: 12:56 A.

3b DATE OF DEATH (Month Day Yr): MARCH 12, 1993

4 SOCIAL SECURITY NUMBER: 307-01-0093

5a AGE—Last Birthday (Years): 75

5b UNDER 1 YEAR (Months, Days)

5c UNDER 1 DAY (Hours, Minutes)

6 DATE OF BIRTH (Mo. Day Yr): July 14, 1917

7 BIRTHPLACE (City and State or Foreign Country): Calumet City, Illinois

8a WAS DECEDENT A U S VETERAN? No

8b YEAR LAST SERVED IN US ARMED FORCES? None

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): THE COMMUNITY HOSPITAL

9c CITY, TOWN OR LOCATION OF DEATH: MUNSTER

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): Divorced

11 SURVIVING SPOUSE (If wife, give maiden name): None

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Custodian

12b KIND OF BUSINESS/INDUSTRY: Morton High School

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Hammond

13d STREET AND NUMBER: 6530 Alexander Ave.,

13e ZIP CODE: 46323

13f INSIDE CITY LIMITS: [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? USA

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): 8; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Joseph Grabarek

19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ucki

INFORMANT

20a INFORMANT'S NAME (Type/Print): Raymond Rygiel

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 428 Westchester Lane Vlaparaiso, Indiana 46383

20c Relationship: Son.

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 16, 1993 St. John Cemetery

21c LOCATION—City or Town, State: Hammond, Indiana

22a EMBALMER'S NAME: Henry J. Blake

22b EMBALMER'S LICENSE NO.: FD01019406

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Ellen B LaHayne

24b LICENSE NUMBER (of Licensee): FD01000857

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LaHAYNE Funeral Home, Inc., FH83002885 5746 Hohman Ave., Hammond, Indiana 46320

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. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF)

b. CORONARY ARTERY DISEASE

DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

c.

DUE TO (OR AS A CONSEQUENCE OF)

Approximate Interval Between Onset and Death

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

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

FILED

JUN 25 1993

Anna N. Anton

AUDITOR LAKE COUNTY

RECEIVED FOR RECORD JUN 30 1993

STATE OF INDIANA, LAKE COUNTY, FILED FOR RECORD

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): NO

CERTIFIER

29a CERTIFIER (Check only one):

[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. MAR 15 1993

[ ] 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: Paik, M.D.

29c MEDICAL LICENSE NO: 30770

29d DATE SIGNED (Month, Day, Year): MARCH 12, 1993

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. JAY C. L. PAIK, M. D. 200 MONTICELLO DRIVE DYER, INDIANA 46311

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD (HEALTH COMMISSIONER)

32 DATE FILED (Month, Day, Year): March 15, 1993

CORONER USE ONLY

33 MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined

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): 01225

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

Lt 14, ex N 30 FT ALL LT 15, BK 3 Meyn Park PB 20/4 Kaplan's Turner

6/25/93

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER PD 1