

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

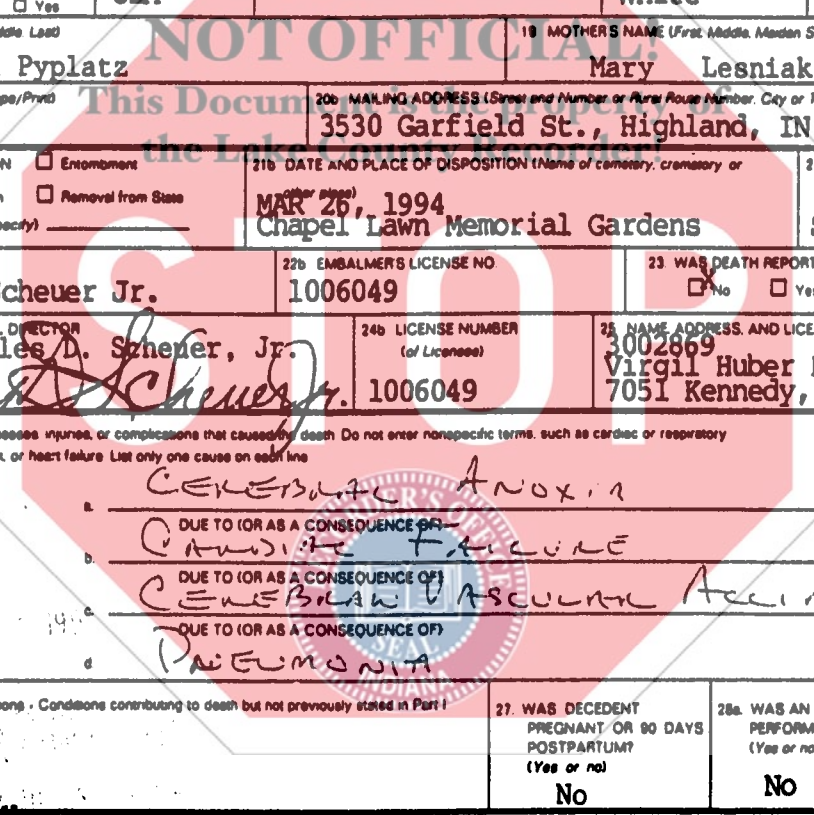
Send to Bills; ~~XXXXXXXXXX~~
Carol Ritchey, 8416 Fairbanks, Crown Point, IN 46307

Local No. 0697-94 94027351 CERTIFICATE OF DEATH State No. Dr. *Ray Markley, 1801 Stoneledge*

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

TYPE/PRINT IN PERMANENT BLACK INK	1 DECEASED—NAME (First Middle Last) Eleanor Markley Baltrus		2 SEX Female	3a TIME OF DEATH 6:20P M	3b DATE OF DEATH (Month Day Yr) March 22, 1994
	4 SOCIAL SECURITY NUMBER 310-22-4955	5a AGE—Last Birthday (Years) 87	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) SEP 5, 1906
DECEDENT	8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
	9b FACILITY NAME (If not institution, give street and number) Regency Place Nursing Home		9c CITY, TOWN OR LOCATION OF DEATH Dyer		9d COUNTY OF DEATH Lake
PARENTS	10 MARITAL STATUS Widowed	11 SURVIVING SPOUSE (Specify, give maiden name) NONE	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 Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Highland	13d STREET AND NUMBER 3724 Highway Avenue	
INFORMANT	13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify) White
	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12		18 FATHER'S NAME (First Middle Last) Joseph Pyplatz	
DISPOSITION	18 MOTHER'S NAME (First Middle, Maiden Surname) Mary Lesniak		20a INFORMANT'S NAME (Type/Print) Eileen Toth		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3530 Garfield St., Highland, IN 46322
	20c Relationship Daughter		21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MAR 26, 1994 Chapel Lawn Memorial Gardens	
CAUSE OF DEATH	21c LOCATION—City or Town, State Scherverville, Indiana		22a EMBALMER'S NAME Charles D. Scheuer Jr.		22b EMBALMER'S LICENSE NO. 1006049
	22c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		23 SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer, Jr.</i>		23a ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323
HEALTH OFFICER	24 SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer, Jr.</i>		24b LICENSE NUMBER (of Licensee) 1006049		24c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323
	25 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. <i>Cerebral Anoxia</i> MINUTES b. <i>CARDIAC FAILURE</i> MINUTES c. <i>Cerebral Vascular Accident</i> WEEKS d. <i>PNEUMONIA</i> DAYS PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
CERTIFIER	26a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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		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) N/A		29a SIGNATURE AND TITLE OF CERTIFIER <i>Alexander Williams</i>		29b MEDICAL LICENSE NO. 2300470
HEALTH OFFICER	29c DATE SIGNED (Month Day, Year) March 24, 1994		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Lester James Daros D.O., 3100 - 45th Avenue, Highland, IN 46322		31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams</i>
	32 DATE FILED (Month Day, Year) APR 12 1994		33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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 ADDRESS (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		34i		34j	

key # 27-32-27 Pt. Ed SW SE S. J. T. 36 B. 9 E. S. 1/2 135 135 135 135



FILED APR 12 1994

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