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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 22 12-94 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): Helen Dobrowolski
2. Sex: Female
3a. Time of Death: 4:30 pm
3b. Date of Death (Month, Day, Yr): September 9, 1994
4. Social Security Number: 340-12-3886
5a. Age—Last Birthday (Years): 71
5b. Under 1 Year (Months, Days):
5c. Under 1 Day (Hours, Minutes):
6. Date of Birth (Mo. Day, Yr): May 19, 1923
7. Birthplace (City and State or Foreign Country): Chicago, Il
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): 500 E. 23rd. Court
9c. City, Town or Location of Death: Lake Station
9d. County of Death: Lake
10. Marital Status (Specify): Married
11. Surviving Spouse (If wife, give maiden name): Theodore E. Dobrowolski
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired): Clerical Assistant
12b. Kind of Business/Industry: Office of Spec. Dep.
13a. Residence—State: IN
13b. County: Lake
13c. City, Town or Location: Lake Station
13d. Street and Number: 500 E. 23rd. Court
13e. Zip Code: 46405
13f. Inside City Limits: ☐ No ☒ Yes
13g. On a Farm? ☒ No ☐ Yes
14. Citizen of What Country: U.S.A.
15. Was Decedent of Hispanic Origin? (Specify No or Yes — If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify): White
17. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

9500009169

PARENTS

18. Father's Name (First, Middle, Last): John Filip
19. Mother's Name (First, Middle, Maiden Surname): Katie (Barna) Filip

INFORMANT

20a. Informant's Name (Type/Print): Theodore E. Dobrowolski
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 E. 23rd. Court, Lake Station, IN 46405
20c. Relationship: Husband

DISPOSITION

21a. Method of Disposition: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place): September 13, 1994, Holy Cross Cemetery
21c. Location—City or Town, State: Calumet City, Il
22a. Embalmer's Name: Philip E. Engel
22b. Embalmer's License No.: FDO 8800224
23. Was Death Reported to Coroner? ☒ No ☐ Yes
24a. Signature of Funeral Director: [signature]
24b. License Number (of Licensee): FDO 9200094
25. Name, Address, and License Number of Funeral Home: Engel Funeral Home FDH 3007889, 2700 Willowcreek Road, Portage, IN 46368

THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. JAN 05 1995 [signature] Alexander S. Williams MD, HEALTH COMMISSIONER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 JAN -5 PM 12:03 MARSHA G. COLEY CHIEF DEP. RECORDER

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. CARDIAC ARREST	1 Day
	Due to (or as a consequence of):	
	Due to (or as a consequence of):	
Conditions, if any, leading to the immediate cause, stating the underlying cause last	Due to (or as a consequence of):	

FILED JAN -5 1995

Part II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: CHRONIC MYELOID LEUKEMIA

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):
☒ 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: [signature]
29c. Medical License No.: 01030107
29d. Date Signed (Month, Day, Year): 9-15-94

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Bharat Barai MD 125 E. 89th Ave, Merrillville, IN 46410

HEALTH OFFICER

31. Health Officer's Signature: Alexander S. Williams MD
32. Date Filed (Month, Day, Year): September 16, 1994

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):
34g. Date Pronounced Dead (Month, Day, Year):
34h. Motor Vehicle Accident? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

267 90

SDH05-004 State Form 10110 (R4/3-93) Deathcer/PD 1