

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

INDIANA STATE DEPARTMENT OF HEALTH

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

Local No. 44 190685

CERTIFICATE OF DEATH

JAN 18 1994 Date Issued
Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

TICOR TILE INSURANCE
Green-Peace, Indiana

PARENTS

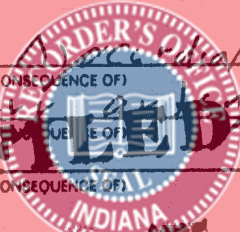
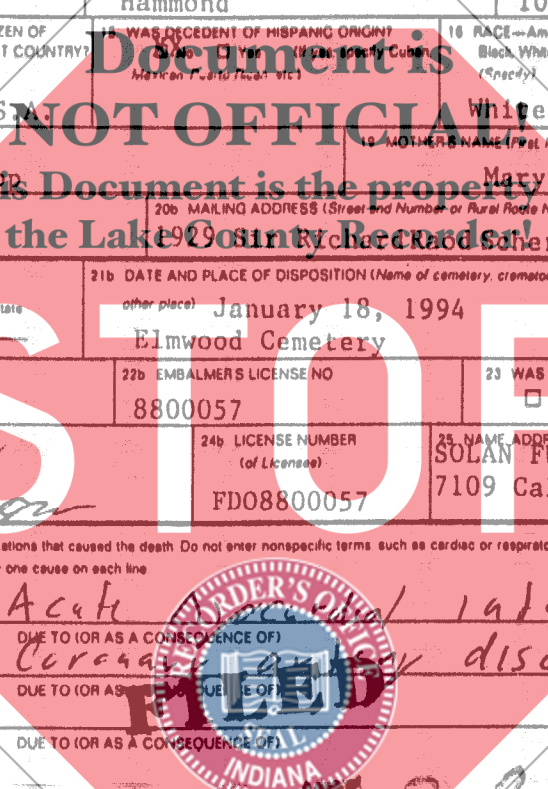
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) HELEN KRIZMIS		2 SEX Female	3a TIME OF DEATH 8:30A M	3b DATE OF DEATH (Month, Day, Yr) January 15, 1994
4 SOCIAL SECURITY NUMBER 306-10-8097	5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) August 24, 1914
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana	8a PLACE OF DEATH (Check only one See instructions)			
8a WAS DECEDENT A US VETERAN? NO	8b YEAR LAST SERVED IN US ARMED FORCES? None	HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		
9a FACILITY NAME (If not institution, give street and number) 1026-167th Street		9b CITY, TOWN, OR LOCATION OF DEATH Hammond	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife, give maiden name) None	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife	12b KIND OF BUSINESS/INDUSTRY Homemaker	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 1026-167th Street	
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? (Specify) White	16 RACE—American Indian, Black, White, etc. (Specify)
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary; Secondary (10-12); College (S*) 11 years		18 FATHER'S NAME (First, Middle, Last) Frank Palupchak		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary Palupchak		20a INFORMANT'S NAME (Type/Print) Barbara Golec		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5001 197th Street, Schererville, IN 46375		20c Relationship Daughter		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) January 18, 1994 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Indiana	
22a EMBALMER'S NAME Dean G. Wagner		22b EMBALMER'S LICENSE NO. 8800057	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licensee) FDO8800057	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN FUNERAL HOME PH# 83002893 7109 Calumet Ave., Hammond Ind. 46324	
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) Acute myocardial infarction				
DUE TO (OR AS A CONSEQUENCE OF) Coronary artery disease				
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 mentioned				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28 WAS AN AUTOPSY PERFORMED? (Yes or no) NO		29b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
29a 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.				
29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			29c MEDICAL LICENSE NO. 01027640	29d DATE SIGNED (Month, Day, Year) Jan. 17, 1994
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Lawrence D. Bernstein M.D. 5500 Hohman Ave. Suite 1 D Hammond, INdiana 46320				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>				32 DATE FILED (Month, Day, Year) JANUARY 18, 1994
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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 LOCATION (Street and Number or Rural Route Number, City, or Town, State) 000234		34g DATE PRONOUNCED DEAD (Month, Day, Year)		
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		34i		



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
CHIEF DEP. RECORDER
AM10:31