

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

CERTIFICATE OF DEATH

Local No. 1342-94

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

1 DECEASED—NAME (First, Middle, Last) Antanas Zilenas		2 SEX Male	3a TIME OF DEATH 8:15 A.M.	3b DATE OF DEATH (Month, Day, Yr) June 15, 1994
4 SOCIAL SECURITY NUMBER 311-32-7621	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) May 13, 1915
7 BIRTHPLACE (City and State or Foreign Country) Lithuania	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) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
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 Married	11 SURVIVING SPOUSE (If wife, give maiden name) Helen Zeleznik	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Grinder + Inspector	12b KIND OF BUSINESS/INDUSTRY Manufacturing Co.	
13a RESIDENCE—STATE INDIANA	13b COUNTY Lake	13c CITY TOWN OR LOCATION Highland	13d STREET AND NUMBER 8416 Parrish Pl.	
13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary 10-12: College (1-4 or 5+) 2		18 FATHER'S NAME (First, Middle, Last) Joseph Zilenas		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable		20a INFORMANT'S NAME (Type/Print) Helen Zilenas		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8416 Parrish Pl, Highland, Indiana		20c Relationship Wife		
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) June 18, 1994 Resurrection Cemetery		21c LOCATION—City or Town, State Hammond, Indiana	
22a EMBALMER'S NAME Ronald A. Reed	22b EMBALMER'S LICENSE NO. FDO 1001081	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (or License) FDO 1014511	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleiman Rd, Highland, Indiana FDH 300-7500		
26 CAUSE OF DEATH (Injury, 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 result of complication resulting in death) Gastric ulcer bleed, hemorrhagic CONDITIONS WHICH GAVE RISE TO IMMEDIATE CAUSE (List only one cause on each line) Peptic ulcer disease, chronic, severe Arteriosclerosis of arteries				
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 IS THE BODY AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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 Ronald A. Reed		29c MEDICAL LICENSE NO. 01018389	29d DATE SIGNED (Month, Day, Year) 6/16/94	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Ronald A. Reed 36414 Ridge Rd Highland IN 46322				
31 HEALTH OFFICER'S SIGNATURE Alexander D. Williams, M.D.				32 DATE FILED (Month, Day, Year) June 17, 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"/> Homicide <input type="checkbox"/> 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.		34i		



FILED
JAN 30 1995
SAM ORLICH
AUDITOR LAKE COUNTY

Highland Park 1st Add
N 50ft lot 22 and
S 25ft lot 21
Key #27-241-22
Unit # 16

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL DEATH RECORD WITH THE HEALTH DEPT
ALEXANDER D. WILLIAMS, M.D.
LAKE COUNTY HEALTH COMMISSIONER