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

Jan 24 1995 — Date Issued — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 285

Key#. 35-207-13

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Bennie Mazurek
2 SEX: Male
3a TIME OF DEATH: 9:05 p M
3b DATE OF DEATH (Month, Day, Yr): April 2, 1992
4 SOCIAL SECURITY NUMBER: 313-01-6678
5a AGE—Last Birthday (Years): 84
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day. Yr.): August 22, 1907
7 BIRTHPLACE (City and State or Foreign Country): Butler, Pennsylvania
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: None
8c PLACE OF DEATH (Check only one. See instructions): HOSPITAL [XX] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
8d FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
8e CITY, TOWN, OR LOCATION OF DEATH: Hammond
8f COUNTY OF DEATH: Lake
9 MARITAL STATUS (Specify): Married
10 SURVIVING SPOUSE (If wife, give maiden name): Sophie Gregorczyk
11a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laboratory Technician
11b KIND OF BUSINESS/INDUSTRY: Standard Oil Co.
12a RESIDENCE—STATE: Indiana
12b COUNTY: Lake
12c CITY, TOWN OR LOCATION: Hammond
12d STREET AND NUMBER: 6338 Euclid
12e ZIP CODE: 46324
12f INSIDE CITY LIMITS? [ ] No [XX] Yes
12g ON A FARM? [XX] No [ ] Yes
13 CITIZEN OF WHAT COUNTRY?: U.S.A.
14 WAS DECEDENT OF HISPANIC ORIGIN? [XX] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
15 RACE—American Indian, Black, White, etc. (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 years; College (1-4 or 5+): ---

PARENTS

17 FATHER'S NAME (First, Middle, Last): Wojciech Mazurek
18 MOTHER'S NAME (First, Middle, Maiden Surname): Aleksandra Rutzki

INFORMANT

19a INFORMANT'S NAME (Type/Print): Sophie Mazurek
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6338 Euclid Hammond, Indiana 46324
19c Relationship: Wife

DISPOSITION

20a METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 5, 1992 St. John Cemetery
20c LOCATION—City or Town, State: Hammond, Indiana
21a EMBALMER'S NAME: Charles W. Wells
21b EMBALMER'S LICENSE NO.: #1042372
22 WAS DEATH REPORTED TO CORONER? [XX] No [ ] Yes
23a SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan
23b LICENSE NUMBER (of Licensee): FD#1051840
24 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FD#83002893 7109 Calumet Ave., Hammond, Ind. 46324

STATE OF IN... LAKE COUNTY FILED FOR RECORD 95 FEB 23 PM 8:58 RECORDER'S OFFICE

FILED FEB 23 1995 SAM ORLICH AUDITOR LAKE COUNTY

CAUSE OF DEATH

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. Possible Pulmonary Embolism
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last.
Approximate Interval Between Onset and Death:

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Extensive Deep Vein Thrombosis Carcinoma of Lung
26. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
27a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
27b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

CERTIFIER

28a CERTIFIER (Check only one):
[XX] 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

28b SIGNATURE AND TITLE OF CERTIFIER: [signature]
28c MEDICAL LICENSE NO.: 32247
28d DATE SIGNED (Month, Day, Year): April 5, 1992
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): Dr, U Shah 2315 East 93rd Street Suite 240 chicago, Il 60617

HEALTH OFFICER

30 HEALTH OFFICER'S SIGNATURE: [signature]
31 DATE FILED (Month, Day, Year): April 6, 1992

CORONER USE ONLY

32 MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
33a DATE OF INJURY (Month, Day, Year)
33b HOUR OF INJURY
33c INJURY AT WORK? (Yes or no)
33d DESCRIBE HOW INJURY OCCURRED
33e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
33f 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.

001053

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Blackmun, Boomberger & Moran, 9006 Indianapolis Blvd., Highland 6/38