

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

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

#95-11939
NATIONS TITLE AGENCY OF INDIANA INC.
9292 North Meridian St. Suite 110
Indianapolis, Indiana 46260
State No. ...

Local No. ... 2162-94 ...

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) JOANN J. ZACK		2 SEX Female	3a TIME OF DEATH 9:25P	3b DATE OF DEATH (Month Day, Yr) September 8, 1994	
4 *SOCIAL SECURITY NUMBER 305-20-0703	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) NOV 6, 1924	
7 BIRTHPLACE (City and State or Foreign Country) CALUMET CITY, IL	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. 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) 1300 RIPLEY STREET	9c CITY, TOWN OR LOCATION OF DEATH LAKE STATION	9d COUNTY OF DEATH LAKE	9500588		
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If not, give name) NICHOLAS ZACK	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done or most of work (Do not use retired)) CANTEN WORKER	12b KIND OF BUSINESS/INDUSTRY INTERSTATE MAIL		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION LAKE STATION	13d STREET AND NUMBER 1300 RIPLEY STREET		
13e ZIP CODE 46405	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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 (0-12) <input checked="" type="checkbox"/> College (1, 4 or 5+)	18 FATHER'S NAME (First Middle Last) JOHN				
19 MOTHER'S NAME (First Middle Maiden Surname) KONDRA STEPHANIE		20c Relationship Gorlowski			
20a INFORMANT'S NAME (Type/Print) NICHOLAS ZACK		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 RIPLEY ST, LAKE STATION, IN 46405		20c Relationship Husband	
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) SEP 12, 1994 CALVARY CEMETERY		21c LOCATION—City or Town, State PORTAGE, INDIANA		
22a EMBALMER'S NAME JAMES J. KRAUSE	22b EMBALMER'S LICENSE NO. FD01006463	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Kenneth P. Flowers</i>	24b LICENSE NUMBER (of Licensee) FD08900027	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOME, BRADY CHASE 3781 CENTRAL AV LAKE STATION, IN 46405			
26 PART I: Enter the disease, 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>Coronary heart failure (cardiac arrest)</i> b. <i>Due to (or as a consequence of) metastatic breast carcinoma</i> c. <i>Due to (or as a consequence of)</i> d. <i>Due to (or as a consequence of)</i> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.		27 WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No			
28a WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b THE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No			
29a CERTIFIER (Check only one) <input 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>Alexander Williams</i>		29c MEDICAL LICENSE NO. D10 33934	29d DATE SIGNED (Month, Day, Year) 9/12/94		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ASHWANI KUMAR MD, 3156 WILLOWCREEK ROAD, PORTAGE, IN 46368					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>		32 DATE FILED (Month, Day, Year) 9-12-94			
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 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.			



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDING
NOV 17 1995
AUDITOR SAM ORR
LAKE COUNTY

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