[redacted]

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

Feb. 15, 1996 (signature)
Date Issued — Hammond Health Commissioner

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 129

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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): Jan Baran
2 SEX: Male
3a TIME OF DEATH: 3:15 PM
3b DATE OF DEATH (Month Day Yr): February 12, 1996
4 *SOCIAL SECURITY NUMBER: 339-28-8344
5a AGE—Last Birthday (Years): 85
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day Yr): Sep. 1, 1910
7 BIRTHPLACE (City and State or Foreign Country): Polland
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): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Health Care North
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Johanna Schwoff
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Foreman
12b KIND OF BUSINESS/INDUSTRY: Office Supplies
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 3372 Burr St.
13e ZIP CODE: 46406
13f INSIDE CITY LIMITS: ☐ No X Yes
13g ON A FARM?: X No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: Poland
15 WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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 (0-12) / College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Unavailable
19 MOTHER'S NAME (First, Middle, Maiden Surname): Unavailable

INFORMANT

20a INFORMANT'S NAME (Type/Print): Johanna Baran
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3372 Burr st. Gary, Indiana 46406
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial XX Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 16, 1996 Oakland Memory Lane
21c LOCATION—City or Town, State: Dolton, Illinois
22a EMBALMER'S NAME: N/A
22b EMBALMER'S LICENSE NO: N/A
23 WAS DEATH REPORTED TO CORONER? X No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: (signature) A Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 FEB 22 MARION CLEVELAND 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. ACUTE CEREBROVASCULAR ACCIDENT — DAYS
DUE TO (OR AS A CONSEQUENCE OF)
b. HYPERTENSIVE HEART DISEASE — YEARS
DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last
c. PROSTATE CANCER — YEARS
DUE TO (OR AS A CONSEQUENCE OF)
d.

FILED FEB 22 1996 SAM ORLICH AUDITOR LAKE COUNTY

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 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

CERTIFIER

29a CERTIFIER (Check only one):
X 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) DO
29c MEDICAL LICENSE NO.: 02001161
29d DATE SIGNED (Month, Day, Year): Feb. 2/15/96
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 1573 N. CLINE AVE, GRIFFITH, IN 46319 C. FORCIT JR. D.O.

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin J. Oremunde M.D.
32 DATE FILED (Month, Day, Year): FEB 15 1996

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

001196 900/15

9-12-10 Burn Ave. Ins 10

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

PS.