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

Katz & Brennan 7805 Brdwy Merrill 46410

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 96-2 State No.

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): Helen Engelhart	2. SEX: Female	3a. TIME OF DEATH: 4 AM M	3b. DATE OF DEATH (Month, Day, Yr): January 2, 1996	
4. *SOCIAL SECURITY NUMBER: 31314-9330	5a. AGE—Last Birthday (Years): 72	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo, Day, Yr): Sept.18,1923
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, In.	8a. WAS DECEDENT A U.S. VETERAN?: no	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: none		

9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number): 5628 Wegg Ave.,	9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago	9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed	11. SURVIVING SPOUSE (If wife, give maiden name): none	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home	13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago	13d. STREET AND NUMBER: 5628 Wegg	13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes	13g. ON A FARM?: ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Vincent Czapla

19. MOTHER'S NAME (First, Middle, Maiden Surname): Sophie Nocek

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Janet Olesek

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3363W.173pl Merrillville In.46410

20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 5 1996 Holycross Cemetery

21c. LOCATION—City or Town, State: Calumet City, Ill

22a. EMBALMER'S NAME: Henry [illegible]

22b. EMBALMER'S LICENSE NO.: 01019406

23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: Michael Mysliwy

24b. LICENSE NUMBER (of Licensee): 10021419

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Mysliwy Funeral Home 3001619 4902 Reading Ave.,East Chicago,IN46312

FILED FEB 2 2 1996 SAM ORLICH AUDITOR LAKE COUNTY

960 3963

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. Metastatic Stomach Cancer

DUE TO (OR AS A CONSEQUENCE OF) b.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF) c.

DUE TO (OR AS A CONSEQUENCE OF) d.

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

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 FEB 26 AM 8:55 [illegible] RECORDER

CERTIFIER

29a. CERTIFIER (Check only one): ☒ 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: Salwan Gailani

29c. MEDICAL LICENSE NO.: 27970

29d. DATE SIGNED (Month, Day, Year): 1/2/96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. D. Gailani, M.D., 9116 Columbia Ave., Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [illegible]

32. DATE FILED (Month, Day, Year): 1-5-96

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.

001056

Key# 30-595-13

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