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Local No. 810

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

Oct 15, 1991 — Date Issued — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Alice H. Maruszczak
2. SEX: Female
3a. TIME OF DEATH: 3:00 a.m.
3b. DATE OF DEATH (Month, Day, Yr.): October 12, 1991
4. SOCIAL SECURITY NUMBER: 314-20-2367
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): Dec. 11, 1911
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A US VETERAN?: No
8b. YEAR LAST SERVED IN US ARMED FORCES?: -
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
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): Welder
12b. KIND OF BUSINESS/INDUSTRY: Chain Company
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 240 - 142nd Street
13e. ZIP CODE: 46327
13f. INSIDE CITY LIMITS: [ ] No [XX] Yes
13g. ON A FARM?: [XX] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.): [XX] No [ ] Yes
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Julius Gloza
19. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Okraj

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Judy Maruszczak
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 240 - 142nd Street, Hammond, In 46327
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 15, 1991 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City, Illinois
22a. EMBALMER'S NAME: Keith D. Anthony
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER?: [XX] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Anthony & Dziadowicz FH 83002835, 4404 Cameron, Hammond, In 46327

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. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Perforated appendix
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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):

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: S Sharma MD
29c. MEDICAL LICENSE NO.: 31739
29d. DATE SIGNED (Month, Day, Year): October 12, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. Sharma, M. D. 57 Clinton Street, Hammond, Indiana 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Fremund M.D.
32. DATE FILED (Month, Day, Year): October 15, 1991

CORONER USE ONLY

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...

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 FEB 2 ... 20 MARGARET ... RECORDER

FILED FEB 2 - 1996

SAM ORLICH AUDITOR LAKE COUNTY 001293

950019702

Unit #26 Key #33-61-9 Add W 15 ft of Lot 9 & E 14 ft of Lot 10, Block 10 Eschenberg's State Line Add

900 / 5 5

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