Copies Mail to 3120 Lakeside Dr

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

27-488-29

Local No. 265

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Ted Peters

2 SEX: Male

3a TIME OF DEATH: M

3b DATE OF DEATH (Month, Day, Yr): September 29, 1996

4 SOCIAL SECURITY NUMBER: #12-16-4276

5a AGE—Last Birthday (Years): 70

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo. Day. Yr): Apr. 28, 1926

7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana

8a WAS DECEDENT A US VETERAN? YES

8b YEAR LAST SERVED IN US ARMED FORCES? 1945

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. Catherine Hospital

9c CITY, TOWN OR LOCATION OF DEATH: East Chicago

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Mary Simko

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Owner

12b KIND OF BUSINESS/INDUSTRY: Industrial Disposal

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Highland

13d STREET AND NUMBER: 3120 Lake Side Dr.

13e ZIP CODE: 46322

13f INSIDE CITY LIMITS? [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Anthony Pietrowski

19 MOTHER'S NAME (First, Middle, Maiden Surname): Frances Lelinski

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary Peters

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3120 Lake Side Dr. Highland, Indiana

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Entombment [ ] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 4, 1996 Chapel Lawn Cemetery

21c LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: Raymond E. White

22b EMBALMER'S LICENSE NO: FD08700086

23 WAS DEATH REPORTED TO CORONER? [ ] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: 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 FH83000900

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Pneumi

DUE TO (OR AS A CONSEQUENCE OF): b. thru CHF

DUE TO (OR AS A CONSEQUENCE OF): c. Septecemia

DUE TO (OR AS A CONSEQUENCE OF): d. AFib

Approximate Interval Between Onset and Death

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

28 WAS AUTOPSY PERFORMED? (Yes or no): YES

29 WERE AUTOPSY FINDINGS CONSIDERED IN COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

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: Sami

29c MEDICAL LICENSE NO: 01032690

29d DATE SIGNED (Month, Day, Year): 9-30-96

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. Sami Ahmadsai 6924 Indianapolis Blvd. Hammond, IN

31 HEALTH OFFICER'S SIGNATURE: no.

32 DATE FILED (Month, Day, Year): 10-1-96

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.

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9/6

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