TTENTION ESTATE: Disclosure of the # we need to pursue our responsibilities oluntary and there will be no penalty for usal.*

Key # 14-175-1

cal No. 2005-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

YPE/PRINT IN ERMANENT LACK INK

CEDENT

ENTS

ORMANT

POSITION

USE OF ATH

RTIFIER

ALTH FICER

1. DECEASED—NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
Wallace A. Lukaszewski	Male	9:20 AM	September 7,1995

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr)	7. BIRTHPLACE (City and State or Foreign Country)
311-18-9796	74			May 18,1921	East Chicago,IN

8a. WAS DECEDENT A US VETERAN?	8b. YEAR LAST SERVED IN US ARMED FORCES?	9. PLACE OF DEATH (Check only one See instructions)
Yes	1945	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
707 Wellington Dr.	Dyer	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Alice Soltys	Truck Driver	East Chicago School System

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Dyer	707 Wellington Dr.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican, Puerto Rican, etc)	16. RACE—American Indian Black White etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46311	☐ No ☐ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12	---

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Frank Lukaszewski	Marcella Slivinski

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Alice Lukaszewski	707 Wellington Dr. Dyer, IN 46311	Wife

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	September 11,1995 Calumet Park Cemetery	Merrillville,IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
James Porras	1045964	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1021590	Burns-Kish Funeral Home#1004968 8415 Calumet Munster, In 46321

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. Acute Non-Lymphocytic Leukemia

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.

THIS CERTIFICATE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

SEP 08 1995

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Coronary Artery Disease Chronic Obstructive Pulmonary Disease	No	No	---

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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
Richard Krejsa - Physician	0200100 2.	Sept. 8,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
Roger Krejsa D.O. 2068 Lincoln Pkwy Lowell,IN

31. HEALTH OFFICER'S SIGNATURE [signature] M.D.

32. DATE FILED (Month, Day, Year) September 8,1995

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

OR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.

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)

APR 29 1997

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no)	34i. If yes, specify driver, passenger, pedestrian, etc.

SAM ORLICH
AUDITOR LAKE COUNTY

001733

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