Return To: 11L Title Corp - 8043 Taylor Ave. - Munster IN 46321

Key # 06-364-47

* 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

CERTIFICATE OF DEATH

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

Local No. 770

S Oct 6, 1997 Date Issued — Hammond Health Commissioner

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)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
ANNA	KLISIAK	FEMALE	1:03 AM	OCTOBER 2, 1997

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)
306-24-7613	72			MAY 20, 1925	CALUMET CITY, ILLINOIS

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	-	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARGARET MERCY HOSPITAL	HAMMOND	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
DIVORCED	NONE	BOOKKEEPER	BLUE PRINT COMPANY

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	4210 TOWLE AVENUE

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+)
46327	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	12	

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
WALTER WISNIEWSKI	HELEN WITKOWSKI

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
ALBIN KLISIAK JR.	1851 FISHTORN DR., SCHERERVILLE, IN. 46375	SON

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
☐ Entombment ☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)	OCTOBER 6, 1997 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
KEITH D. ANTHONY	01011911	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Keith D Anthony	01011911	ANTHONY & DZIADOWICZ FH 87002835 4404 CAMERON, HAMMOND, INDIANA 463

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. Septic shock
DUE TO (OR AS A CONSEQUENCE OF)
b. Diabetes Mellitus Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Cardiopulmonary arrest
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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	NO

FILED 1997 OCT 6 PM 12:11 SAM ORLICH AUDITOR LAKE COUNTY STATE OF INDIANA

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) and manner 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) and manner 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)
Nelle Zimkani	1042616	OCTOBER 3, 1997

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
A. DIVAKARUNI M.D. 7905 CALUMET AVENUE, MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Evangeline F. Bermuda M.D.	October 6, 1997

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				

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

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

CS