* 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.

Key # 45-241-4

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 97 0566

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): EDNA SCHNEIDEWIND

2 SEX: FEMALE

3a TIME OF DEATH: 4:50 A M

3b DATE OF DEATH (Month Day Yr): AUGUST 13, 1997

4 *SOCIAL SECURITY NUMBER: 355-32-0926

5a AGE—Last Birthday (Years): 85

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo. Day Yr): JULY 23, 1912

7 BIRTHPLACE (City and State or Foreign Country): CHICAGO, ILLINOIS

8a WAS DECEDENT A U.S. VETERAN? NO

8b YEAR LAST SERVED IN U.S. ARMED FORCES? —

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): 8821 LAKESHORE DRIVE

9c CITY, TOWN OR LOCATION OF DEATH: GARY

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): LEGAL SECRETARY

12b KIND OF BUSINESS/INDUSTRY: LUCAS, CLIFFORD & HOLCOMB LAW FIRM

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN, OR LOCATION: GARY

13d STREET AND NUMBER: 8821 LAKESHORE DRIVE

13e ZIP CODE: 46403

13f INSIDE CITY LIMITS ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

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

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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): JOSEPH KACZALA

19 MOTHER'S NAME (First Middle Maiden Surname): MARTHA MARTEWICZ

INFORMANT

20a INFORMANT'S NAME (Type/Print): PAMELA J. HRUSKOVICH

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7950 JUNIPER AVE., GARY, INDIANA 46403

20c Relationship: DAUGHTER

DISPOSITION

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

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): AUGUST 16, 1997 HOLY CROSS CEMETERY

21c LOCATION—City or Town, State: CALUMET CITY, ILLINOIS

22a EMBALMER'S NAME: GORDON L. JONES

22b EMBALMER'S LICENSE NO: 01010711

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: James E. Burns

24b LICENSE NUMBER (of Licensee): 01009461

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME, FDH# 83002380, 701 E. 7TH STREET, HOBART, IN. 46342

97 007 04

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. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):
b. Metastatic Carcinoma of left breast

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

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)

97 OCT 15 AM 11:

MORTUARY

STATE OF INDIANA LAKE COUNTY FILED RECORDED

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 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) and manner 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: R. R. Barton MD

29c MEDICAL LICENSE NO: 17667 In

29d DATE SIGNED (Month, Day, Year): 8-18-97

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): R. R. BARTON, M. D., 6101 MILLER AVENUE, GARY, INDIANA 46403

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:

32 DATE FILED (Month, Day, Year): AUG 18 1997

FILED

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:

1. 1997

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):

SAM ORLICH
AUDITOR LAKE COUNTY

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

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