* 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.

Local No. 0101-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	Aloysius F. Fetcko
2. Sex	Male
3a. Time of Death	5:30PM
3b. Date of Death (Month Day Yr)	April 3, 1996
4. Social Security Number	200-07-5311
5a. Age—Last Birthday (Years)	74
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo Day Yr)	FEB 20, 1922
7. Birthplace (City and State or Foreign Country)	Cannonsburg, PA
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces?	1946
9a. Place of Death	Hospital: [X] Inpatient [ ] ER/Outpatient [ ] DOA; Other: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. Facility Name	St. Anthony Medical Center
9c. City, Town or Location of Death	Crown Point
9d. County of Death	Lake
10. Marital Status	Married
11. Surviving Spouse (If wife, give maiden name)	Dolores Florian
12a. Decedent's Usual Occupation	Underwriter
12b. Kind of Business/Industry	Insurance
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town or Location	Crown Point
13d. Street and Number	221 Maple Street
13e. Zip Code	46307
13f. Inside City Limits	[ ] No [X] Yes
13g. On a Farm?	[X] No [ ] Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin?	[X] No [ ] Yes
16. Race	White
17. Decedent's Education (Elementary/Secondary 0-12; College 1-4 or 5+)	12 / 1

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	Frank Fetcko Sr.
19. Mother's Name (First, Middle, Maiden Surname)	Julia Sarnosky

INFORMANT

Field	Entry
20a. Informant's Name	Dolores Fetcko
20b. Mailing Address	221 Maple St., Crown Point, IN 46307
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other
21b. Date and Place of Disposition	APR 8, 1996 St. Mary's Cemetery
21c. Location—City or Town, State	Crown Point, IN.
22a. Embalmer's Name	Larry A. Geisen
22b. Embalmer's License No	FD09000013
23. Was Death Reported to Coroner?	[X] No [ ] Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FD01000328
25. Name, Address and License Number of Funeral Home	FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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.

	Cause	Approximate Interval Between Onset and Death
a. Immediate Cause	Metastatic Carcinoma of Colon	4 months
b. Due to (or as a consequence of)		
c. Due to (or as a consequence of)		
d. Due to (or as a consequence of)		

PART II — Other significant conditions: Arteriosclerotic Heart Disease

Field	Entry
27. Was Decedent Pregnant or Postpartum?	
28a. Was an Autopsy Performed?	No
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death?	No

FILED
OCT 30 1997
SAM ORLICH
AUDITOR LAKE COUNTY

CERTIFIER

29a. Certifier: [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.

Field	Entry
29b. Signature and Title of Certifier	J A Kacmar M.D.
29c. Medical License No	01027088
29d. Date Signed	4/4/96
30. Name and Address of Person Who Completed Cause of Death	Joseph A. Kacmar M.D., 423 N. Court Street, Crown Point, IN 46307

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Alexander S. Williams, M.D.
32. Date Filed	April 8, 1996
33. Manner of Death	[X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
34a. Date of Injury	
34b. Time of Injury	
34c. Injury at Work?	
34d. Describe How Injury Occurred	
34e. Place of Injury	
34f. Location	
34g. Date Pronounced Dead	
34h. Motor Vehicle Accident?	

CERTIFIED TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

OCT 24 1997

001824

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

9.00 pd

FILED FOR RECORD OCT 31 1997 STATE OF INDIANA LAKE COUNTY

7-183-6

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