[redacted] ISSUED BY MARION COUNTY HEALTH DEPARTMENT [redacted] ROSEMARY 1029 / 100000595965
INDIANA STATE DEPARTMENT OF HEALTH 12/1951 F 02/06/95
[redacted] PSON, JAMES M MD EYE

Local No. .....

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

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
ROSEMARY M. WOZNIAK	FEMALE	6:12 PM	FEB.-26-95

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)
317565301	43			MARCH 12-51	INDPLS, IN

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	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
METHODIST HOSPITAL	INDIANAPOLIS	MARION

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	TERRANCE WOZNIAK	DEPUTY ASSESSOR	WINFIELD TWP.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	WINFIELD TOWNSHIP	4183 THORNHILL DRIVE

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 +)
46307	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE		4

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
DAVID MURPHY	FERN JONES

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
TERRANCE WOZNIAK	4183 THORNHILL DR. CROWN POINT IN 46307	HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City, Town, State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	MARCH 3, 1995 MAPLEWOOD MEMORIAL CEM.	CROWN POINT, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
VAN WALTERS	08900032	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
DON K. Hunt	1024174	PRUZIN BROS. FUNERAL SERVICE 6360 BROADWAY, MERRILLVILLE, IN

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 Pneumonia	Days
	DUE TO (OR AS A CONSEQUENCE OF) b NON HODGKINS LYMPHOMA	1 Yr
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	

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I
1) Intracranial hemorrhage
2) Graft vs host disease

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)

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) 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)
Lynn C. Rhard MD	0103114	Feb 26, 1995

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
1633 N. Capitol Indianapolis IN 46202

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE Virginia A. Caine, M.D.

32. DATE FILED (Month, Day, Year) FEB 28 1995

FILED
DEC 01 1997
SAM ORLICH
AUDITOR LAKE COUNTY

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	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.

000071

STATE OF INDIANA LAKE COUNTY FILED OF RECORD
97 DEC 11 AM 11:35
MORRIS W. CARTER RECORDER

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER-PD 1

NOT VALID UNLESS MACHINE NUMBERED AND SIGNED WITH MULTICOLOR RIBBON ON REVERSE SIDE

LOT 457 LAKE OF SEASONS UNIT 2. THE FOUR LAKE CO