

* 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

Donald O'Neil
Box 128
Gowell 46356

Local No. 0080-98

State No. 001620

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

2014 960
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Nancy Horejs		2 SEX Female	3a TIME OF DEATH 7:30 A.M.	3b DATE OF DEATH (Month, Day, Year) January 15, 1998
4 SOCIAL SECURITY NUMBER 336-30-6272	5a AGE—Last Birthday (Years) 58	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo, Day, Yr) February 14, 1939
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? Not Applicable	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 3715 Boulevard Drive		9c CITY, TOWN OR LOCATION OF DEATH Highland	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) James Horejs	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker	12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Highland	13d STREET AND NUMBER 3715 Boulevard Drive	
13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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+) 1	18 FATHER'S NAME (First, Middle, Last) Louis Viga		19 MOTHER'S NAME (First, Middle, Maiden Surname) Anna (Unavailable)	
20a INFORMANT'S NAME (Type/Print) James Horejs		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3715 Boulevard Dr., Highland, Indiana 46322		20c Relationship Spouse
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) January 17, 1998 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Schererville, Indiana
22a EMBALMER'S NAME Edgar C. Gleim		22b EMBALMER'S LICENSE NO. FDO1016173	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>David A. Peterson</i>		24b LICENSE NUMBER (of License) FDO8601585	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Road, Highland, Indiana 46322 FH83007500	
26 PART I. Enter the disease, 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 OF DEATH (This is a true and accurate copy of the certificate resulting from the autopsy and should be filed with the Lake County Health Dept.) Metastatic Cancer of the breast DUE TO (OR AS A CONSEQUENCE OF) HEALTH DEPT. FILED JAN 16 1998 DUE TO (OR AS A CONSEQUENCE OF) FILED DUE TO (OR AS A CONSEQUENCE OF)				
26 PART II. Enter any significant conditions or conditions contributing to death, such as chronic disease, pregnancy, or drug use. Atherosclerosis, Hypertension LAKE COUNTY HEALTH COMMISSIONER		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) Not Applicable
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Salman Qasbi</i> AUDITOR LAKE COUNTY		29c MEDICAL LICENSE NO. 1027970
29d DATE SIGNED (Month, Day, Year) 1/15/98		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) S.D. GAILANI, MD, 916 COUNTRIDGE, MUNSTER, IN 46321		
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Gailani, MD</i>		32 DATE FILED (Month, Day, Year) January 16, 1998		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED		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.		001620 900 150 3366

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER