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* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

Local No. 223-97

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

20079
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

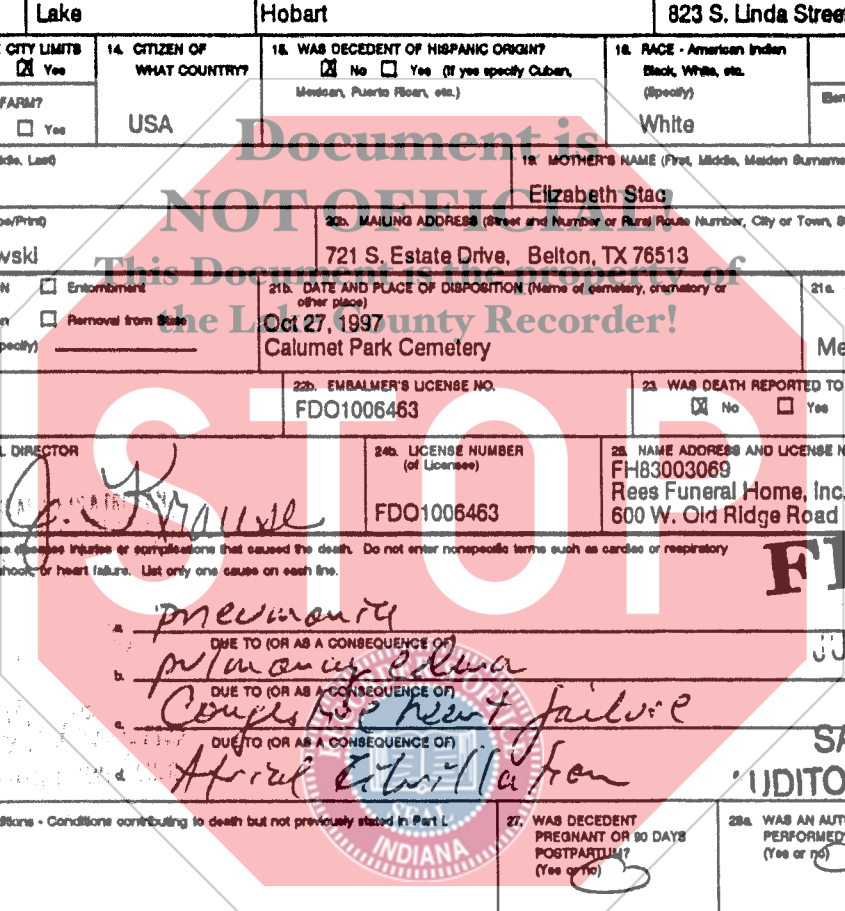
PARENTS

INFORMANT

DISPOSITION

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

1. DECEASED-NAME (First Middle Last) JOSEPH BADANISH		2. SEX Male	3a. TIME OF DEATH 3:40PM	3b. DATE OF DEATH (Month Day Yr) October 21, 1997	
4. SOCIAL SECURITY NUMBER 312-05-3344	5a. AGE - Last Birthday (Years) 97	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Jan 31, 1900	
7. BIRTHPLACE (City and State or Foreign Country) Punxsutawney, Pennsylvania	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9b. CITY TOWN OR LOCATION OF DEATH Hobart		9c. 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) Roller		12b. KIND OF BUSINESS INDUSTRY Steel	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 823 S. Linda Street		
13a. ZIP CODE 46342	13e. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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+) 6		18. FATHER'S NAME (First, Middle, Last) Jacob Badanish			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Stac		20. INFORMANT'S NAME (Type/Print) Marilyn Rae Bardowski			
20a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 721 S. Estate Drive, Belton, TX 76513		20b. Relationship Niece			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) Oct 27, 1997 Calumet Park Cemetery		21c. LOCATION - City or Town State Merrillville, Indiana	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FDO1006463	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	24c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342		
25. 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 (Final disease or condition resulting in death) a. pneumonia b. pneumonia, edema c. Complete heart failure d. Atrial fibrillation CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST e. Hypertension					
25. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.					
26. 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.		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/>			
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/>			
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Mark O. Carter</i>		29b. MEDICAL LICENSE NO. 01036415	29c. DATE SIGNED (Month Day Year) 10/29/97		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) Mark O. Carter MD, 295 S. Wisconsin Street, Hobart, IN 46342					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Wilkins MD</i> DATE FILED (Month Day Year) October 27, 1997					
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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) 9.00 cm LY			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 000104 LY			



FILED
JUN 01 1997
SAM ORLICH
AUDITOR LAKE COUNTY