

MINNESOTA DEPARTMENT OF HEALTH  
Section of Vital Statistics  
**CERTIFICATE OF DEATH**

280798000190 State File Number

Local File Number

1a Name of Deceased - First <b>CHARLES</b>		Middle <b>B</b>	Last <b>JANDURA</b>		Suffix
1e Alias <b>Chuck</b>		2 Social Security Number <b>307-38-0625</b>		3 Sex <b>Male</b>	4 Date of Death <b>February 9, 1998</b>
5 Date of Birth <b>February 27, 1940</b>		6a Age (in years) <b>57</b>		7 Place of Birth (city and state/foreign country) <b>Gary, Indiana</b>	
8a Father's Name (first middle) <b>Adam</b>		8b Father's Last Name <b>Jandura</b>		8 Mother's Name (first middle maiden surname) <b>Rose Matson</b>	
10 Race <b>White</b>		11a Hispanic Origin <b>No</b>	11b If Yes, Specify Cuban, Mexican, etc.		12 Decedent's Education 12a Primary/Secondary (0-12) <b>12</b> 12b College (1-4, 5+)
13a Marital Status <b>Married</b>		13b Name of Spouse (if wife, specify maiden name) <b>Sharon Foss</b>		14 Decedent's Usual Occupation <b>Pipefitter</b>	
15 Kind of Business or Industry <b>Steel Manufacturing</b>		16 U.S. Veteran <b>No</b>	17a State of Residence <b>Indiana</b>		17b County of Residence <b>Lake</b>
17c City or Township of Residence <b>Hobart</b>		17d Address of Decedent (number and street) <b>7208 Randolph Street</b>			17e Zip Code <b>46342</b>
17e Residence in City or Township <b>City</b>		18a City or Township of Death <b>Rochester</b>		18b County of Death <b>Olmsted</b>	
19a Place of Death <b>XXX Hosp N.H. Res Other</b>		Other Place of Death		19b If Hospital <b>XXX Inpatient ER DOA Other</b>	
19c Name of Facility Where Death Occurred (if not institution, street address) <b>Saint Marys Hospital</b>					
20a Name of Informant <b>Sharon Jandura</b>			20b Informant's Relationship to Decedent (spouse, child, parent, sibling, etc.) <b>Spouse</b>		
21 Method of Disposition (specify all that apply) <b>X Burial</b> Cremation Donation Entombment Other				22 Date of Disposition <b>February 13, 1998</b>	
23 Name of Cemetery <b>Calumet Cemetery</b>			23a City <b>Merrillville, Indiana</b>		
24 If Cremation, Specify Name of Crematory			25 If Cremation, Specify Name of M.E. / Coroner Authorizing Cremation		
26a Name of Funeral Establishment <b>Macken Funeral Home, Inc.</b>		26b License No. <b>0228</b>	27a Signature of Funeral Service Licensee <i>Bryan J. Hanson</i>		27b License No. <b>3455</b>
28a Name of Person Certifying Cause of Death - PLEASE TYPE <b>Johannes Bjornsson, M.D.</b>		28b Title <b>XX M.D. Coroner/M.E. D.O.</b>		28c License Number of Certifier <b>26490</b>	
29a Address of Certifier (number and street) <b>In/For the Mayo Clinic</b>		29b City <b>Rochester</b>		29c State <b>Minnesota</b>	29d Zip Code <b>55905</b>
30a Signature of M.E. / Coroner / D.O. <i>Johannes Bjornsson</i>		31 Date Signed <b>February 17, 1998</b>		32 Signature of Registrar <i>Joan M. Doesen</i>	
33a Date Filed <b>2-24-98</b>					
34 PART I > TYPE Enter the diseases, injuries, or complications that caused death. Do not enter the mode of dying such as cardiac or respiratory shock or heart failure. Enter only one cause per line.					
a. IMMEDIATE cause of death (final disease or condition resulting in death) <b>Pneumonia.</b>				Interval between onset and death <b>3 weeks</b>	
b. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING cause last (disease or injury that initiated events resulting in death) <b>Creutzfeld-Jakob disease.</b>				<b>3 months</b>	
35 I attended the deceased from <b>01/21/98</b> to <b>02/09/98</b> and last saw him on <b>02/09/98</b> I viewed the body after death <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				36 Time of Death <b>4:25 a.m.</b>	
36 PART II > TYPE <b>Hypertension.</b>					
Other significant conditions contributing to death but not resulting in the underlying cause specified in PART I.					
37 Was Female Pregnant: At Death? Yes No Unknown In Last 12 Months? Yes No Unknown					
38 MANNER OF DEATH					
XXX Natural		40 M.E./Coroner Notified Yes <b>XX</b> No		41 Autopsy Yes <b>XX</b> No	
		42 Were Autopsy Results Available When Filing in Cause of Death? Yes No		43 Diagnostic Deferred Yes No	
44a Place of Injury (number and street, city / township, state)					
44b Describe How Injury Occurred					
44c Type of Place Where Injury Occurred		44d Date of Injury		44e Time of Injury	
44f Injury at Work Yes No					

Signature of Sub-Registrar - Date  
*Joan M. Doesen* 2-23-98

NOT OFFICIAL

STOP

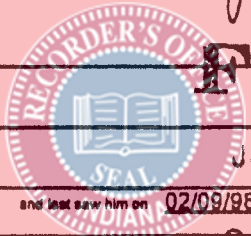
FILED

JUN 09 1998

RECORDER'S OFFICE

SEAL

OFFICIAL



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**CLERK LAKE COUNTY**

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101 NORTH MAIN STREET  
CROWN POINT, INDIANA  
46307

STATE OF MINNESOTA  
COUNTY OF OLMSTED

I certify this to be a true copy of  
the original record in my custody.

Dated 3-2-98  
Dante J. Hall  
County Recorder  
By Joan M. Doesen

*900 km*  
**000785**

**CK# 13398**