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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave., Suite 104 Valparaiso, IN 46383

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) NANCY K. GRUSZKA		2. SEX Female	3a. TIME OF DEATH 5:50PM	3b. DATE OF DEATH (Month Day Yr) April 24, 1998
4. SOCIAL SECURITY NUMBER 312-42-8951	5a. AGE - Last Birthday (Years) 55	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Jul 18, 1942
7a. WAS DECEDENT A U.S. VETERAN? No	7b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	8a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) Valparaiso Care & Rehab. Ctr.		9b. CITY TOWN OR LOCATION OF DEATH Valparaiso	9c. COUNTY OF DEATH Porter	
10. MARITAL STATUS (Specify) Divorced	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) Homemaker	12b. KIND OF BUSINESS INDUSTRY Home	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Gary	13d. STREET AND NUMBER 356 S. Howard Street	
13e. ZIP CODE 46403	13f. 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 (1-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Sam O. Troutman		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Laura McGraw		20a. INFORMANT'S NAME (Type/Print) Ben G. Gruszka		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 N. Guyer, Hobart, IN 46342		20c. Relationship Son		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) Apr 29, 1998 Galvany Crematory		21c. LOCATION - City or Town Portage, 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 license) FDO1006463	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003068 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342	
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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions if any which gave rise to the immediate cause stating the underlying cause last				
a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF)				
b. Comm DUE TO (OR AS A CONSEQUENCE OF)				
c. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF)				
d.				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.				
27a. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		27b. WAS AN AUTOPSY PERFORMED? (Yes or no)		27c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No		No		No
28a. 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.				
28b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			28c. MEDICAL LICENSE NO. 01024990	28d. DATE SIGNED (Month Day Year) April 28, 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) John L. Swamer MD, 1101 E. Glendale Blvd., Valparaiso, IN 46383				
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Bobbaker MD</i>				32. DATE FILED (Month Day Year) April 29, 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"/> Homicide <input type="checkbox"/> Could not be Determined		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.		34i. 001246		



MOBILE RECORDER
 APPROXIMATE Interval Between Death and Death
 98 JUN 18 AM 8
 STATE OF INDIANA
 LAKE COUNTY
 FILED FOR RECORD

Document No. 590475

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PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA

This Document is a true copy of
the Lake County Recorder's Office

THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

Gary A. Balcoke, MD
HEALTH OFFICER

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