

* 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

State No.

Local No. 1545-98

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Frank J. Polak			2 SEX male		3a TIME OF DEATH 10:50P		3b DATE OF DEATH (Month Day Yr) July 4, 1998		
4 *SOCIAL SECURITY NUMBER 313-12-5635		5a AGE—Last Birthday (Year) 75	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) February 10, 1923		7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana		
8a WAS DECEDENT A U.S. VETERAN? yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? Unavailable		9a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence					
9b FACILITY NAME (If not institution, give street and number) The Community Hospital				9c CITY, TOWN OR LOCATION OF DEATH Munster,		9d COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) married		11 SURVIVING SPOUSE (If wife, give maiden name) Irene Fowler		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Food Service		12b KIND OF BUSINESS/INDUSTRY Lounge Operator			
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY TOWN OR LOCATION Highland		13d STREET AND NUMBER 3102 Lake Side Drive			
13e ZIP CODE 46322		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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 2	
18 FATHER'S NAME (First Middle Last) Frank Polak				19 MOTHER'S NAME (First Middle Maiden Surname) Josephine (Unknown)					
20a INFORMANT'S NAME (Type/Print) Irene Polak				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 Lake Side Drive Highland, Indiana 46322			20c Relationship wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) July 6, 1998 Calumet Park Cemetery			21c LOCATION—City or Town, State Merrillville, Indiana			
22a EMBALMER'S NAME David R. Peterson			22b EMBALMER'S LICENSE NO. FDO8601585		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR <i>C.A. Kuiper</i>			24b LICENSE NUMBER (of Licensee) FDO1014511		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 (Final disease or condition resulting in death) a acute hypoxic encephalopathy DUE TO (OR AS A CONSEQUENCE OF) b cerebral vasculature accident DUE TO (OR AS A CONSEQUENCE OF) c diabetes mellitus type 2 DUE TO (OR AS A CONSEQUENCE OF) d hypertension PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I								Approximate Interval Between Onset and Death	
27 WAS AN AUTOPSY PERFORMED? (Yes or no) no					28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) n/a				
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, SAM ORLICH and place and due to the cause(s) and manner as stated			29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> AUDITOR LAKE COUNTY		29c LICENSE NO. 02001522		29d DATE SIGNED (Month Day Year) 7/6/98		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) David Forest 00, 1572 Park Lane, Eau Claire, WI 54601									
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. [Signature]</i>							32 DATE FILED (Month Day Year) July 7, 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			
34a 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. UUU687 900 km						