* 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.

Local No. 625

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE A COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

AUG. 14, 1998 Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): STEVE M. KRISTEK
2. SEX: MALE
3a. TIME OF DEATH: 10:00A.M.
3b. DATE OF DEATH (Month Day Yr): AUGUST 12, 1998
4. SOCIAL SECURITY NUMBER: 305-20-0185
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): MAY 20, 1926
7. BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
8a. WAS DECEDENT A U.S. VETERAN? YES
8b. YEAR LAST SERVED IN US ARMED FORCES? 1946
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 1336 LAKEVIEW STREET
9c. CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS: MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): HARLA J. LILAND
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ACCOUNTING CLERK
12b. KIND OF BUSINESS/INDUSTRY: AMOCO OIL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HAMMOND(WHITING P.O.)
13d. STREET AND NUMBER: 1336 LAKEVIEW STREET
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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+):

PARENTS

18. FATHER'S NAME (First Middle Last): STEFAN KRISTEK
19. MOTHER'S NAME (First Middle Maiden Surname): EVA M. FULIER

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MRS. HARLA J. KRISTEK
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1336 LAKEVIEW, WHITING, IN 46394
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): AUGUST 15, 1998 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, IND.
22a. EMBALMER'S NAME: MARTIN A. DYBEL
22b. EMBALMER'S LICENSE NO: FDE01019456
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

98 38 0867

CAUSE OF DEATH

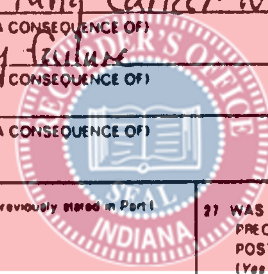
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Small cell lung cancer with metastasis — Approximate Interval Between Onset and Death: 10 months
DUE TO (OR AS A CONSEQUENCE OF)
b. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A



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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 98 SEP 18 ... SAM ORLICH AUDITOR LAKE COUNTY

CERTIFIER

29a. CERTIFIER (Check only one): XX CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. ☐ 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. ☐ 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: [signature] MD
29c. MEDICAL LICENSE NO: 01045528B
29d. DATE SIGNED (Month Day Year): AUG. 14, 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ANITA T.C. LEE, M.D., 5454 HOHMAN AVE., HAMMOND, INDIANA 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Dremeda M.D. [signature]
32. DATE FILED (Month Day Year): August 14, 1998

33. MANNER OF DEATH: X Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

001289

#36-201-17

Ck# 3412

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1