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PORTER COUNTY CERTIFICATE OF DEATH

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

Key # 46-582-28

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) MICHAEL J. NADOLSKI		2 SEX Male	3a TIME OF DEATH 10:45 P.M.	3b DATE OF DEATH (Month, Day, Yr) September 28, 1999	
4 *SOCIAL SECURITY NUMBER 313-07-0483	5a AGE—Last Birthday (Years) 87	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) September 27, 1912	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois	8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? --		
9a 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					
9b FACILITY NAME (If not institution, give street and number) Canterbury Place		9c CITY, TOWN, OR LOCATION OF DEATH Valparaiso		9d COUNTY OF DEATH Porter	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Helen Roszkowski	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker		12b. KIND OF BUSINESS/INDUSTRY U.S. Steel	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 5224 Georgia Street		
13e. ZIP CODE 46409	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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/Secondarily (0-12) 8 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Leon Nadolski			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Stasiak		20a. INFORMANT'S NAME (Type/Print) Helen Nadolski			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5224 Georgia St., Gary, Indiana 46409		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) October 2, 1999 Calvary Cemetery		21c. LOCATION—City or Town, State Portage, Indiana	
22a. EMBALMER'S NAME Amy DeMunck		22b. EMBALMER'S LICENSE NO. FI29900059		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) 1009893		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410	
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) Severe coronary artery disease, CHF DUE TO (OR AS A CONSEQUENCE OF) Hypertension CONDITIONS OF 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) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) --	
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, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. MEDICAL LICENSE NO. 01245239		29d. DATE SIGNED (Month, Day, Year) 10/1/99			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Muhammad M. Kudaimi, M.D., 751 East 81st Place, Merrillville, IN 46410					
31. HEALTH OFFICER'S SIGNATURE 			32. DATE FILED (Month, Day, Year) OCT 12 1999		
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 PETER BENJAMIN LAKE COUNTY AUDITOR
34e. PLACE OF INJURY—At home farm street factory office building, etc. (Specify)		34g. DATE PRONOUNCED DEAD (Month, Day, Year)			
34f. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		34h. DATE FILED (Month, Day, Year) 100723 9:00 PM			