* 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. 2266-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

#269138

TYPE/PRINT IN PERMANENT BLACK INK

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

99086499

99 OCT 21 AM 8:49

DECEDENT

1 DECEASED—NAME (First, Middle, Last): PETER HALKIAS

2. SEX: Male

3a TIME OF DEATH: 3:01p.M

3b DATE OF DEATH (Month Day Yr): October 6, 1999

4. SOCIAL SECURITY NUMBER: 305-30-4010

5a AGE—Last Birthday (Years): 66

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo Day Yr): Nov. 26,1932

7 BIRTHPLACE (City and State or Foreign Country): GAry, Indiana

8a WAS DECEDENT A US VETERAN? Yes

8b YEAR LAST SERVED IN US ARMED FORCES? 1954

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number): St. Mary Medical Center

9c CITY, TOWN OR LOCATION OF DEATH: Hobart

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Single

11 SURVIVING SPOUSE (If wife, give maiden name):

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Retired Acct.

12b KIND OF BUSINESS/INDUSTRY: NIPSCO

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 4175 Ellsworth St.

13e ZIP CODE: 46408

13f INSIDE CITY LIMITS: ☒ No ☐ Yes

13g ON A FARM? ☐ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? USA

15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

16 RACE—American Indian, Black, White, etc. (Specify): Cau

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

PARENTS

18 FATHER'S NAME (First, Middle, Last): Xarkos Halkias

19 MOTHER'S NAME (First, Middle, Maiden Surname): Corinne Koulianos

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary Halkias

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4175 Ellsworth St. GAry, In 46408

20c Relationship: Sister

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): October 8, 1999 Ridgelawn Cemetery

21c LOCATION—City or Town, State: GAry, Indiana

22a EMBALMER'S NAME: Anthony S. Rendina Jr.

22b EMBALMER'S LICENSE NO: FD01010402

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Anthony S. Rendina Jr

24b LICENSE NUMBER (of Licensee): FD01010402

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Rendina Funeral HOme FH83007819 5100 Cleveland St. Gary,In46408

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) a: Lung Cancer

b DUE TO (OR AS A CONSEQUENCE OF)

c DUE TO (OR AS A CONSEQUENCE OF)

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

d DUE TO (OR AS A CONSEQUENCE OF)

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

OCT 07 1999

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED

OCT 20 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

CERTIFIER

29a CERTIFIER (Check only one):
☒ 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: M. Ton Gaspa[illegible]

29c MEDICAL LICENSE NO: 01S 3757S

29d DATE SIGNED (Month Day Year): 07 Oct 99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MILTON GASPARIS 1500 So. LAKE PR AVE HOBART, IN

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD

32 DATE FILED (Month Day Year): October 7, 1999

33 MANNER OF DEATH: ☐ 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

001354

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.

9 10 pm

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

2595

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