20CC

SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 2165-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Key # 7-232-11

State No. ....

265247

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)	MICHAEL J. STOLARZ
2 SEX	MALE
3a TIME OF DEATH	12:30 AM
3b DATE OF DEATH (Month, Day, Yr)	SEPT. 26, 1999
4 *SOCIAL SECURITY NUMBER	308-66-9415
5a AGE - Last Birthday (Years)	41
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo, Day, Yr)	JUNE 12, 1958
7 BIRTHPLACE (City and State or Foreign Country)	GARY, INDIANA
8a WAS DECEDENT A U S VETERAN?	NO
8b YEAR LAST SERVED IN U S ARMED FORCES?	N/A
PLACE OF DEATH (Check only one)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b FACILITY NAME (If not institution, give street and number)	11428 DELAWARE STREET
9c CITY, TOWN OR LOCATION OF DEATH	CROWN POINT
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name)	VIKKI R. BENJAMIN
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	MANAGER
12b KIND OF BUSINESS/INDUSTRY	MIKE'S SPORTING GOODS
13a RESIDENCE - STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN OR LOCATION	CROWN POINT
13d STREET AND NUMBER	11428 DELAWARE ST.
13e ZIP CODE	46307
13f INSIDE CITY LIMITS	☐ No X Yes
13g ON A FARM?	X No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN?	X 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)	MICHAEL E. STOLARZ
19 MOTHER'S NAME (First, Middle, Maiden Surname)	JANET J. BLANK

INFORMANT

20a INFORMANT'S NAME (Type/Print)	VIKKI R. STOLARZ
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	11428 DELAWARE ST., CROWN POINT, IN 46307
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)	SEPT.30, 1999 CALVARY CEMETERY
21c LOCATION - City or Town, State	PORTAGE INDIANA
22a EMBALMER'S NAME	GORDON L. JONES
22b EMBALMER'S LICENSE NO	1010711
23 WAS DEATH REPORTED TO CORONER?	XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Terrence P. Burns
24b LICENSE NUMBER (of Licensee)	1013890
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns Funeral Home FH83002445 10101 Broadway, Crown Point, Indiana 46307-8801

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 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. Non-Small Cell Lung Cancer

b. DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — c. DUE TO (OR AS A CONSEQUENCE OF)

d. DUE TO (OR AS A CONSEQUENCE OF)

CERTIFIED TRUE COPY OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. SEP 27 1999 Alexander S. Williams, M.D. LAKE COUNTY HEALTH OFFICER

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I	
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U)	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)	N/A

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	R Drasga
29c MEDICAL LICENSE NO	01031484
29d DATE SIGNED (Month, Day, Year)	9/17/99
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DR. RAY DRASGA, 8127 MERRILLVILLE ROAD, MERRILLVILLE, INDIANA

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, M.D.
32 DATE FILED (Month, Day, Year)	September 27, 1999

FILED

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	
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.	

OCT 27 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

9.00 E.P. CS

State Form 10130 (R4/3-93) Deathcer/DP-1

001614