

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 OF INDIANA
LAKE COUNTY State No.
FILED FOR RECORD

Local No. 25-49-99

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) Walter S. Kozol		2 SEX Male	3a TIME OF DEATH 6:48 P.M.	3b DATE OF DEATH (Month Day, Yr.) November 5, 1999	
4 *SOCIAL SECURITY NUMBER 316-14-7726		5 UNDER 1 DAY 77	6 DATE OF BIRTH (Mo. Day, Yr.) Jul. 20, 1922	7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9 PLACE OF DEATH (Check only one) (See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> RESIDENCE <input checked="" type="checkbox"/>			
9b FACILITY NAME (If not institution, give street and number) 624 N. Rensselaer		9c CITY, TOWN OR LOCATION OF DEATH Griffith	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Stella Knafla	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Stillman	12b KIND OF BUSINESS/INDUSTRY Oil Refinery		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Griffith	13d STREET AND NUMBER 624 N. Rensselaer St.		
13e ZIP CODE 46319	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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2		18 FATHER'S NAME (First Middle Last) Edward Koziolkiewicz			
19 MOTHER'S NAME (First Middle Maiden Surname) Mary Szczygielski		20a INFORMANT'S NAME (Type/Print) Stella Kozol			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 N. Rensselaer St., Griffith, Ind. 46319		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" 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) November 9, 1999 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Schererville, Indiana	
22a EMBALMER'S NAME David R. Peterson		22b EMBALMER'S LICENSE NO. FDO 8601585	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Rd Highland, Indiana 46322 FH 83007500		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) NOV 12 1999 <i>acute myocardial infarction</i> Smoker					
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) 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) 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 <i>Alexander S. Williams</i>		29c MEDICAL LICENSE NO. 101042561	29d DATE SIGNED (Month Day, Year) 11/10/99		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) KRISHNAKANT RAIKER, MD 9038-B Columbia Ave. Munster, IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams</i>			32 DATE FILED (Month Day, Year) November 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 INFLUENCING FACTORS (If any) DESCRIBE HOW INJURY OCCURRED FILED	
34g DATE PRONOUNCED DEAD (Month Day Year)		34d MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify			
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) cash		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) JAN 19 2000			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify			
PETER BENJAMIN etc LAKE COUNTY AUDITOR		01248 \$9.00 dw			

Key # 26-154-3537, +
St. Mary's Add lots 35, 36, 37, + 38 Block 2