* 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

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

Local No. 589

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

FEB 7 2000
Date Issued

Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
MARY T. RASCHKE	FEMALE	10:55A M	JULY 23, 1999

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
326-24-5060	2008	010842		FEB. 1, 1914	WHITING, INDIANA

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
HAMMOND/WHITING CARE CENTER	HAMMOND	LAKE

10 MARITAL STATUS (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
WIDOWED	NONE	HOMEMAKER	OWN HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	WHITING	1712 CENTER STREET

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN?	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
46394	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes (If yes specify Cuban Mexican Puerto Rican etc)	WHITE	Elementary/Secondary (0-12) 6	College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
JOSEPH SEKETA	MARGARET POZDARRC

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
MR. HENRY RASCHKE	1431 LAKE AVE., WHITING, IN 46394	SON

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	JULY 26, 1999 ST. JOHN CEMETERY	HAMMOND, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
MARTIN A. DYBEL	FDE01019456	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Martin A. Dybel	FDE01019456	BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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 ARTERIOSCLEROTIC HEART DISEASE	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b DUE TO (OR AS A CONSEQUENCE OF) DEMENTIA	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d DUE TO (OR AS A CONSEQUENCE OF)	

FILED
FEB 15 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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

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

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
	010369954	JULY 24, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
T. ABBASI, M.D., 17680 S. KEDZIE AVE., HAZEL CREST, IL 60429

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Franklin D. Gremillion M.D.	July 27, 1999

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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

BURNET TITLE K# 25-121-14

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