* 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. 482

STATE OF INDIANA
LAKE COUNTY

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

INDIANA STATE DEPARTMENT OF HEALTH

2000 013666

CERTIFICATE OF DEATH

RECORD

Jun 11 1998 — Hammond Health Commissioner

MORRIS W. CARTER

#36-488-19

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1 DECEASED—NAME (First Middle Last)	PETE DUTCZAK
2 SEX	Male
3a TIME OF DEATH	6:50 P.M.
3b DATE OF DEATH (Month Day Yr)	June 12, 1998
4 *SOCIAL SECURITY NUMBER	323-36-0201
5a AGE—Last Birthday (Years)	70
5b UNDER 1 YEAR Months Days	
5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr)	October 31, 1927
7 BIRTHPLACE (City and State or Foreign Country)	Perevoloka, Ukraine
8a WAS DECEDENT A U.S. VETERAN?	NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number)	7144 McLaughlin Avenue
9c CITY, TOWN OR LOCATION OF DEATH	Hammond
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Maria Winarczyk
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Fitter
12b KIND OF BUSINESS/INDUSTRY	Howard Industries
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	7144 McLaughlin Avenue
13e ZIP CODE	46324
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	5th
College (1-4 or 5+)	

PARENTS

Field	Value
18 FATHER'S NAME (First Middle Last)	John Dutczak
19 MOTHER'S NAME (First Middle Maiden Surname)	Olena Gazdewicz

INFORMANT

Field	Value
20a INFORMANT'S NAME (Type/Print)	Maria Dutczak
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7144 McLaughlin Ave., Hammond, IN. 46324
20c Relationship	Wife

DISPOSITION

Field	Value
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	June 15, 1998 Holy Cross Cemetery
21c LOCATION—City or Town, State	Calumet City, Illinois
22a EMBALMER'S NAME	Dean G. Wagner
22b EMBALMER'S LICENSE NO	8800057
23 WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	8800057
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, In. 46324

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	CARCINOMA OF LUNG	6 mo.
DUE TO (OR AS A CONSEQUENCE OF) b		
DUE TO (OR AS A CONSEQUENCE OF) c		
DUE TO (OR AS A CONSEQUENCE OF) d		

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

Field	Value
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	N/A
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)
- ☒ 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

Field	Value
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	01030107
29d DATE SIGNED (Month Day Year)	6-17-98
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print)	B.H. Barai, M.D. 9250 Columbia Ave., Munster, In. 46321

HEALTH OFFICER

Field	Value
31 HEALTH OFFICER'S SIGNATURE	Franklin J. Bremude M.D.
32 DATE FILED (Month Day Year)	June 17, 1998

FILED FEB 29 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR
C0215

9.00 E.P.
CS

Field	Value
33 MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.	

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

25x10