* **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.

July 14, 1998 — Date Issued — Hammond Health Commissioner

Local No. 548

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): Anthony R. Komendat — 2000 014372
2 SEX: Male
3a TIME OF DEATH: 10:02 AM
3b DATE OF DEATH (Month Day Yr): July 12, 1998
4 *SOCIAL SECURITY NUMBER: 306-28-1236
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): Jul. 11, 1932
7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a WAS DECEDENT A US VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
8c PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution give street and number): St. Margaret Mercy Health Care North
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): Joan Jelenish
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Roll Grinder
12b KIND OF BUSINESS/INDUSTRY: Steel Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Griffith
13d STREET AND NUMBER: 1640 Norwood Dr.
13e ZIP CODE: 46319
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): Unavailable
19 MOTHER'S NAME (First, Middle, Maiden Surname): Estella Calandra

INFORMANT

20a INFORMANT'S NAME (Type/Print): Joan Komendat
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1640 Norwood Dr. Griffith, Indiana
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): July 15, 1998 — Holy Cross Cemetery
21c LOCATION—City or Town, State: Calumet City, Illinois
22a EMBALMER'S NAME: David Peterson
22b EMBALMER'S LICENSE NO: FDO 8601585
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: A Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
24c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Septic Shock
DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF): c. Cancer mass of Kidneys
DUE TO (OR AS A CONSEQUENCE OF): d.

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

Approximate Interval Between Onset and Death

FILED — JUL 14 1998 — PETER BENJAMIN LAKE COUNTY AUDITOR

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Renal failure

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

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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: [signature]
29c MEDICAL LICENSE NO: 1030716 (July)
29d DATE SIGNED (Month/Day/Year): 7/13/98

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. A. Kheirbek M.D. 8668 Broadway Merrillville, Indiana 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Bermudez M.D.
32 DATE FILED (Month Day Year): July 14, 1998

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): 60632
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

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