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. 829

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

29-124-7

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

Oct. 19, 1999 — Franklin D. Brenneda M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2000 015076

1 DECEASED—NAME (First Middle Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
JOHN A.	KLOCHAN, SR.		MALE	4:09A M	OCTOBER 15, 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)
310-16-2576	79			AUG. 6, 1920	WHITING, INDIANA
8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)			
YES	1946	HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ 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	
ST. MARGARET MERCY HEALTHCARE CNTR.		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	
MARRIED	ANN SAKSA	OPERATOR		AMOCO OIL COMPANY	
13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION		13d STREET AND NUMBER	
INDIANA	LAKE	WHITING		1935 SCHRAGE AVENUE	
13e ZIP CODE	13f INSIDE CITY LIMITS	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 XX Yes	U.S.A.	XX No ☐ Yes (If yes specify Cuban Mexican Puerto Rican etc)	WHITE	Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
	13g ON A FARM? XX No ☐ Yes				
18 FATHER'S NAME (First Middle Last)			19 MOTHER'S NAME (First Middle Maiden Surname)		
JOHN	KLOCHAN		THERESA	SUROVEK	
20a INFORMANT'S NAME (Type/Print)		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)		20c Relationship	
MRS. ANN KLOCHAN		1935 SCHRAGE, WHITING, IN 46394		WIFE	
21a METHOD OF DISPOSITION		21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)		21c LOCATION—City or Town State	
XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)		OCTOBER 18, 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		XX 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	

26 PART I Enter the diseases injuries or complications that caused the death Do not enter non-specific 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 CEREBRAL ANOXIA	MINUTES
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b DUE TO (OR AS A CONSEQUENCE OF) CARCINOMA OF LUNG	MONTHS
	c DUE TO (OR AS A CONSEQUENCE OF) PROSTATIC & RENAL CARCINOMA	YEARS
	d DUE TO (OR AS A CONSEQUENCE OF)	

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

RENAL FAILURE
CORONARY ARTERY DISEASE

27 WAS OPERATION PERFORMED FOR ANY CONDITION IN PART I OR PART II? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
N/A	NO	N/A

FILED
MAR 02 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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: Claude E. Foreit M.D.
29c LICENSE NO: 04010209
29d DATE SIGNED (Month Day Year): OCT. 18, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
CLAUDE E. FOREIT, D.O., 3831 HOHMAN AVENUE, HAMMOND, INDIANA 46327

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Brenneda M.D.
32 DATE FILED (Month Day Year): October 19, 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				9:00 am
	34e PLACE OF INJURY—At home farm street factory office building etc (Specify)			34f LOCATION (Street and Number or Rural Route Number City Town State) 05502 00
34g DATE PRONOUNCED DEAD (Month Day Year): 1935 S	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