* 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. 42

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.

FEB 28 2000 — Date Issued

[signature] — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Helen J. O'Connor
2 SEX	Female
3a TIME OF DEATH	5:50 PM
3b DATE OF DEATH (Month Day Yr)	January 11, 2000
4 *SOCIAL SECURITY NUMBER	172-14-8315
5a AGE—Last Birthday (Years)	80
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	May 4, 1919
7 BIRTHPLACE (City and State or Foreign Country)	Oil City, PA
8a WAS DECEDENT A U.S. VETERAN?	NO
8b YEAR LAST SERVED IN US 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)	Hammond-Whiting Care Center
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)	William O'Connor
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Homemaker
12b KIND OF BUSINESS/INDUSTRY	Own Home
13a RESIDENCE—STATE	IN
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Highland
13d STREET AND NUMBER	8817 Woodward Ave.
13e ZIP CODE	46322
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): 12; College (1-4 or 5+): 2

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Joseph Rybak
19 MOTHER'S NAME (First Middle Maiden Surname)	Josephine Streczywlk

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	William O'Connor
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8817 Woodward Ave., Highland, IN 46322
20c Relationship	Husband

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	January 15, 2000 Chapel Lawn Cemetery
21c LOCATION—City or Town, State	Schererville, IN
22a EMBALMER'S NAME	John T. Noble
22b EMBALMER'S LICENSE NO	9000031
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature] Brian T. Burns
24b LICENSE NUMBER (of Licensee)	
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home #3004968 8415 Calumet Ave. Munster, IN 46321

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Ac. Respiratory Failure	2 DAYS
DUE TO (OR AS A CONSEQUENCE OF) b		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF) c		
DUE TO (OR AS A CONSEQUENCE OF) d		

Field	Entry
PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I	Pneumonia, Anemia, HTN
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)	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	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	34865
29d DATE SIGNED (Month Day Year)	1-13-2000 (January)
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	M. Patel M.D. 835 169th St., Hammond, IN 46324

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature] M.D.
32 DATE FILED (Month Day Year)	January 14, 2000

Field	Entry
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)	
34g DATE PRONOUNCED DEAD (Month Day Year)	
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.	

5 8 1 9 00 / 3518

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

William J. O'Connor
Attorney at Law
5272 Hohman Avenue
Hammond, IN 46320
9722-45

2000 011733

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

FILED MAR 08 2000 PETER BENJAMIN LAKE COUNTY AUDITOR