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* 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. 0292-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. #11-26-21

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): DJURDJIJA MATIJEVIC	2 SEX: FEMALE	3a TIME OF DEATH: 12:00P M	3b DATE OF DEATH (Month Day Yr): JANUARY 31, 1999
4 *SOCIAL SECURITY NUMBER: 308-74-3986	5a AGE—Last Birthday (Years): 85	5b UNDER 1 YEAR (Months, Days) / 5c UNDER 1 DAY (Hours, Minutes):	6 DATE OF BIRTH (Mo Day Yr): MAY 16, 1913
7 BIRTHPLACE (City and State or Foreign Country): JUGOSLAVIA			
8a WAS DECEDENT A US VETERAN?: NO	8b YEAR LAST SERVED IN US ARMED FORCES?: NONE	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): THE COMMUNITY HOSPITAL	9c CITY TOWN OR LOCATION OF DEATH: MUNSTER	9d COUNTY OF DEATH: LAKE	
10 MARITAL STATUS (Specify): WIDOWED	11 SURVIVING SPOUSE (If wife give maiden name): NONE	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: DOMESTIC
13a RESIDENCE—STATE: INDIANA	13b COUNTY: LAKE	13c CITY TOWN OR LOCATION: CROWN POINT	13d STREET AND NUMBER: 9419 BLAINE ST.
13e ZIP CODE: 46307	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? ☒ 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): UNKNOWN; College (1-4 or 5+):		

PARENTS

18 FATHER'S NAME (First Middle Last): MILE SAULA	19 MOTHER'S NAME (First Middle Maiden Surname): UNKNOWN

INFORMANT

20a INFORMANT'S NAME (Type/Print): RONNIE MATIJEVICH	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9419 BLAINE ST. CROWN POINT, IND. 46307	20c Relationship: SON

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FEBRUARY 3, 1999 ST.SAVA CEMETERY	21c LOCATION—City or Town, State: LIBERTYVILLE, ILLINOIS
22a EMBALMER'S NAME: CHARLES WELLS	22b EMBALMER'S LICENSE NO: FDJ1042372	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b LICENSE NUMBER (of Licensee): FD01008300	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME 88800070 7607 W.LINCOLN HWY.CROWN POINT,IN.46307

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. Uremia – Withdrawal of Dialysis
DUE TO (OR AS A CONSEQUENCE OF)
b. End Stage Renal Disease
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	27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (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)

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: [signature]	29c MEDICAL LICENSE NO: 02000848	29d DATE SIGNED (Month Day Year): FEBRUARY 2, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): STEVEN F. MISCHEL, D.O., 222 DOUGLAS, HAMMOND, INDIANA 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD	32 DATE FILED (Month Day Year): 2/2/99

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.			

Stamps: FEB 03 1999; 9 DR; LAKE COUNTY HEALTH DEPARTMENT; FILED 2000; PETER BENJAMIN LAKE COUNTY AUDITOR; RECORDER'S OFFICE SEAL INDIANA

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

→ Mail to: Ronald Ostojic, Atty at Law 6287 Central Ave. Portage, IN 46368