* 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

Local No. 0280-00 State No. .....

3846 23

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): FRANCIS XAVIER O'BRIEN

2 SEX: MALE

3a TIME OF DEATH: 10:45 P.M.

3b DATE OF DEATH (Mo Day Yr): JANUARY 30, 2000

4 *SOCIAL SECURITY NUMBER: 326-24-6352

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): February 6, 1933

7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois

8a WAS DECEDENT A U.S. VETERAN? Yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954

8c PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9a FACILITY NAME (If not institution give street and number): THE COMMUNITY HOSPITAL

9b CITY, TOWN OR LOCATION OF DEATH: MUNSTER

9c COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Sharon A. Misczak

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Truck Driver

12b KIND OF BUSINESS/INDUSTRY: Transportation

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Dyer

13d STREET AND NUMBER: 2351 Hickory Dr

13e ZIP CODE: 46311

13f INSIDE CITY LIMITS? ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? USA

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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Timothy Francis O'Brien

19 MOTHER'S NAME (First Middle Maiden Surname): Mary Evelyn Brey

INFORMANT

20a INFORMANT'S NAME (Type/Print): Sharon A. O'Brien

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2351 Hickory Dr Dyer, Indiana 46311

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 3, 2000 Calumet Park Cemetery

21c LOCATION—City or Town, State: Merrillville, Indiana

22a EMBALMER'S NAME: Edward F. Mullaney

22b EMBALMER'S LICENSE NO: FDO 1007176

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Edward F. Mullaney

24b LICENSE NUMBER (of Licensee): FDO 1007176

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 1183001504 Fagen-Miller Funeral Homes, Inc 1920 Hart St Dyer, Indiana 46311

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac arrest, shock or heart failure. List only one cause on each line. (*Approximate Interval: Onset to Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Pedestrian vs vehicle accident — Due To (Or As A Consequence Of) — Days: 3

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: b. Due To (Or As A Consequence Of): c. Due To (Or As A Consequence Of):

FILED MAR 23 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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

27 WAS DECEDENT PREGNANT OR IN 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): ☒ 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:

29c MEDICAL LICENSE NO: 01038072

29d DATE SIGNED (Month, Day, Year): JANUARY 31, 2000

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): ERWIN L. ROBIN, M.D., 9305 CALUMET AVENUE SUITE A1, MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32 DATE FILED (Month, Day, Year): February 1, 2000

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:

35a PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):

35b LOCATION (Street and Number or Rural Route Number, City or Town, State): 00453

34g DATE PRONOUNCED DEAD (Month, Day, Year):

34h MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.:

9.00 fee CASH

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

25 x 10

* 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

Local No. 0280-00 State No. .....

384622

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
FRANCIS XAVIER O'BRIEN	MALE	10:45 PM	JANUARY 30, 2000

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)
326-24-6352	66			February 6, 1933	Chicago, Illinois

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
Yes	1954	HOSPITAL [X] 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
THE COMMUNITY HOSPITAL	MUNSTER	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	Sharon A. Misczak	Truck Driver	Transportation

13a RESIDENCE—STATE	13b COUNTY	13c. CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Dyer	2351 Hickory Dr

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46311	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	White	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Timothy Francis O'Brien	Mary Evelyn Brey

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Sharon A. O'Brien →	2351 Hickory Dr Dyer, Indiana 46311	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	February 3, 2000 Calumet Park Cemetery	Merrillville, Indiana

22a. EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Edward F. Mullaney	FDO 1007176	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Edward F. Mullaney	FDO 1007176	Fagen-Miller Funeral Homes, FH83001504 1920 Hart St Dyer, Indiana 46311

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. Enter the cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Cerebrovascular accident	Days
DUE TO (OR AS A CONSEQUENCE OF)		
Conditions if any, which gave rise to the immediate cause stating the underlying cause last.	DUE TO (OR AS A CONSEQUENCE OF)	
	DUE TO (OR AS A CONSEQUENCE OF)	

Alexander D. Hilkevich MD

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

Lung Cancer

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)
No	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	29c. MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	01038072	JANUARY 31, 2000

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

ERWIN L. ROBIN, M.D., 9305 CALUMET AVENUE SUITE A1, MUNSTER, INDIANA 46321

31 HEALTH OFFICER'S SIGNATURE — Alexander D. Hilkevich MD

32 DATE FILED (Month, Day, Year) — February 1, 2000

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				

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)
	00453

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

FILED
FEB 01 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

FILED
MAR 28 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

FILED
FEB 01 2000
LAKE COUNTY HEALTH DEPARTMENT

STATE OF INDIANA
FEB 03 2000
DEPARTMENT OF HEALTH

THIS CERTIFICATE IS INCOMPLETE. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

9.00 Fee
CASH