* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED RECORD

Local No. 0093-00

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

2000 025081

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) |
|---|---|---|---|
| STEVE ZACK | Male | 4:45PM | January 10, 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) |
|---|---|---|---|---|---|
| 317-12-2037 | 76 | | | Oct 1, 1923 | HAMMOND, IN |

| 8a. WAS DECEDENT A U.S VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES | 8c. PLACE OF DEATH (Check only one See Instructions) |
|---|---|---|
| Yes | 1945 | HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 8d. FACILITY NAME (If not institution, give street and number) | 8e. CITY TOWN OR LOCATION OF DEATH | 8f. 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 | SALLY S. ZEHNER | MACHINIST | COMBUSTION ENGINEERING |

| 13a. RESIDENCE - STATE | 13b. COUNTY | 13c. CITY TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| IN | LAKE | HAMMOND | 6922 LINDBERG AVENUE |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 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) | |
|---|---|---|---|---|---|---|---|
| 46323 | ☐ No ☒ Yes | ☒ No ☐ Yes | USA | ☐ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) | WHITE | Elementary/Secondary (0-12): 12 | College (1-4 or 5+): |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| STEVE ZACK | MARY FETCH |

**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 |
|---|---|---|
| SALLY S. ZACK | 6922 LINDBERG AVENUE, HAMMOND, IN 46323 | Wife |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | 21c. LOCATION - City or Town State |
|---|---|---|
| ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | Jan 14, 2000 CHAPEL LAWN MEMORIAL GARDENS | Schererville, IN |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| DAVID F. MCCOY | FD08700581 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| | FD01013507 | FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, HAMMOND, IN 46323 |

**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. Refractory Congestive Heart Failure | |
| Conditions if any which gave rise to the immediate cause stating the underlying cause last | DUE TO (OR AS A CONSEQUENCE OF) b. End Stage Dilated Cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF) c. | |
| | DUE TO (OR AS A CONSEQUENCE OF) d. | |

| 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) |
|---|---|---|---|
| Ventricular Arrhythmias, Severe Pneumonia Severe Mitral Regurgitation, Pulmonary Hypertension | No | 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 | 29d. DATE SIGNED (Month Day Year) |
|---|---|---|
| Shashidhar Divakaruni MD | 010140667 | Jan 12, 2000 |

**HEALTH OFFICER**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
SHASHIDHAR DIVAKARUNI, M.D., 9003 CALUMET AVENUE, MUNSTER, IN 46321

31. HEALTH OFFICER'S SIGNATURE Alexander S. Williams, M.D

32. DATE FILED (Month Day Year) January 13, 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 | | | | THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY |

| 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) |
|---|---|
| | JAN 13 2000 |

| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. |
|---|---|
| | 00547 |

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

SDH408-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

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