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

Local No. 39

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

8 Jan 13, 2000
Date Issued

Hammond Health Commissione

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED--NAME (First Middle Last): Mary Valerie Zalewski

2 SEX: Female

3a TIME OF DEATH: 6:45PM

3b DATE OF DEATH (Month Day Yr): January 8, 2000

4 SOCIAL SECURITY NUMBER: 312-50-1868

5a AGE - Last Birthday (Years): 50

5b UNDER 1 YEAR (Months Days):

5c UNDER 1 DAY (Hours Minutes):

6 DATE OF BIRTH (Mo Day Yr): September 25, 1949

7 BIRTHPLACE (City and State or Foreign Country): Liverpool, England

8a WAS DECEDENT A U S VETERAN?: No

8b YEAR LAST SERVED IN U S ARMED FORCES: N/A

8c 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): 1925 Lake Ave.

9c CITY TOWN OR LOCATION OF DEATH: Whiting

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Zane Zalewski

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

12b KIND OF BUSINESS INDUSTRY: Home

13a RESIDENCE - STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Whiting

13d STREET AND NUMBER: 1925 Lake Ave.

13e ZIP CODE: 46394

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): Valentine Domagalski

19 MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Huxley Domagalski

INFORMANT

20a INFORMANT'S NAME (Type/Print): Zane Zalewski

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):

20c Relationship: Husband

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): January 11, 2000 Chapel Lawn Memorial Gardens

21c LOCATION - City or Town State: Schererville, Indiana

22a EMBALMER'S NAME: Henry A. Gray

22b EMBALMER'S LICENSE NO: FD29900123

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Leroy D Johnson

24b LICENSE NUMBER (of Licensee): FDE8900006

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19900009 Virgil Huber Funeral Home 7051 Kennedy Av, , 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. PANCREATIC CARCINOMA — 4 MONTHS
DUE TO (OR AS A CONSEQUENCE OF)
b.
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): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

FILED
APR 24 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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] M.D.

29c MEDICAL LICENSE NO: 02001161

29d DATE SIGNED (Month Day Year): 1/13/00

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): C. E. Foreit, M.D., 3831 Hohman Avenue, Hammond, IN 46327

31 HEALTH OFFICER'S SIGNATURE: Franklin D Brenneke M.D

32 DATE FILED (Month Day Year): January 13, 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:

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.

SDH100-004 State Form 0110-04 (R4 / 3-93) DEATHCERT/FE

→ 4214 Johnson Ave Hammond, In 46327

STATE OF INDIANA LAKE COUNTY AUDITOR