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

Local No. 245

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

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

Mar 23, 2000 — Franklin D. Grenada M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): Jean Marie Dragus
2. SEX: Female
3a. TIME OF DEATH: 12:25PM
3b. DATE OF DEATH (Month Day Yr): March 18, 2000
4. SOCIAL SECURITY NUMBER: 311-18-9736
5a. AGE - Last Birthday (Years): 79
5b. UNDER 1 YEAR Months / Days:
5c. UNDER 1 DAY Hours / Minutes:
6. DATE OF BIRTH (Mo Day Yr): June 29, 1920
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
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): 6817 Olcott Avenue
9c. CITY TOWN OR LOCATION OF DEATH: Hammond
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): Bookkeeper
12b. KIND OF BUSINESS/INDUSTRY: Steel Manufacturing
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 6817 Olcott Avenue
13e. ZIP CODE: 46323
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): Daniel Moran
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Kennedy

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John (J.D.) Dragus
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6817 Olcott Avenue, Hammond, IN 46323
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Other (Specify) ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): March 21, 2000 Regional Cremation Services
21c. LOCATION (City or Town State): Munster, Indiana
22a. EMBALMER'S NAME: Not Done
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Leo J. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Cerebrovascular accident — DUE TO (OR AS A CONSEQUENCE OF)
b. Arteriosclerosis — DUE TO (OR AS A CONSEQUENCE OF)
c. Hemorrhage — DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions if any which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death: 2 Weeks

FILED
APR 25 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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): 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: X Robert Litchfield D.O.
29c. MEDICAL LICENSE NO: 02000573
29d. DATE SIGNED (Month Day Year): March 22, 2000

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Robert Litchfield, D.O., 9003 Calumet Av. Suite 607, Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Grenada M.D.
32. DATE FILED (Month Day Year): March 23, 2000

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

00632 — 9.00 — CASH

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1