Key # . 17-33-51 Lcc
17-33-52

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

Local No. 3006-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED–NAME (First Middle Last): NEVA LUCILLE WALCZAK
2 SEX: Female
3a TIME OF DEATH: 11:46AM
3b DATE OF DEATH (Month Day Yr): December 29, 1999
4 SOCIAL SECURITY NUMBER: 437-30-1954
5a AGE - Last Birthday (Years): 72
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): May 31, 1927
7 BIRTHPLACE (City and State or Foreign Country): Pervis, Mississippi
8a WAS DECEDENT A U S VETERAN?: No
8b YEAR LAST SERVED IN U S ARMED FORCES: N/A
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c CITY TOWN OR LOCATION OF DEATH: Hobart
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Stanley John Walczak
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: Accounting
13a RESIDENCE - STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Hobart
13d STREET AND NUMBER: Rt 1 2810 E Highway 130
13e ZIP CODE: 46342
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); College (1-4 or 5+): 1

PARENTS

18 FATHER'S NAME (First, Middle, Last): Johnathon Wall
19 MOTHER'S NAME (First, Middle, Maiden Surname): Edna (Unknown)

INFORMANT

20a INFORMANT'S NAME (Type/Print): Stanley John Walczak
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State Zip Code): Rt 1 2810 E Highway 130, Hobart, IN 46342
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify) _____
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): January 3, 2000 Calvary Cemetery
21c LOCATION - City or Town State: Portage, Indiana
22a EMBALMER'S NAME: James J. Krause
22b EMBALMER'S LICENSE NO: FDO1006463
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James J Krause
24b LICENSE NUMBER (of Licensee): FDO1006463
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF)
b. coronary Heart 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
Approximate Interval Between Onset And Death

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I
NIDDM cholelithiasis depression
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a WAS AN AUTOPSY PERFORMED? Yes
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

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

CERTIFIER

29b SIGNATURE AND TITLE OF CERTIFIER: R.L. Billena Jr MD
29c MEDICAL LICENSE NO
29d DATE SIGNED (Month Day Year): 1/3/00
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): R.L. Billena Jr MD, 5490 Broadway, Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander R. Billena, M.D
32 DATE FILED (Month Day Year): JAN 4 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