3CC

* 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

Local No. 1720-99 State No. # 19-87-1

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): ELEANOR V. POCIALIK	2 SEX: Female	3a TIME OF DEATH: 12:17AM	3b DATE OF DEATH (Month Day Yr): July 24, 1999
4 SOCIAL SECURITY NUMBER: 316-09-2027	5a AGE - Last Birthday (Years): 76 / 5b UNDER 1 YEAR Months Days / 5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr): November 27, 1922	7 BIRTHPLACE (City and State or Foreign Country): New Chicago, Indiana
8a WAS DECEDENT A U S VETERAN?: No	8b YEAR LAST SERVED IN U S ARMED FORCES: —	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): METHODIST HOSPITAL SOUTHLAKE		9c CITY TOWN OR LOCATION OF DEATH: MERRILLVILLE	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): HOMEMAKER	12b KIND OF BUSINESS INDUSTRY: OWN HOME
13a RESIDENCE - STATE: Indiana	13b COUNTY: Lake	13c CITY TOWN OR LOCATION: Lake Station	13d STREET AND NUMBER: 2800 Clay St.
13e ZIP CODE: 46405 / 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): 10 College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Gregory Gielarowski	19 MOTHER'S NAME (First, Middle, Maiden Surname): Suzanna Bieslada

INFORMANT

20a INFORMANT'S NAME (Type Print): Susan Malocha	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7140 Catherine, MERRILLVILLE, IN 46410	20c Relationship: Daughter

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): July 27, 1999 Calvary Cemetery	21c LOCATION City or Town State: PORTAGE, Indiana
22a EMBALMER'S NAME: JAMES J. KRAUSE	22b EMBALMER'S LICENSE NO: FD01006463	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b LICENSE NUMBER (of Licensee): FDO1006049	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19300009 Rees Funeral Home, Brady Chapel 3781 Central Avenue, Lake Station, IN 46405

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. Cardiac Arrest — Acute
DUE TO (OR AS A CONSEQUENCE OF)
b. Descending Thoracic abdominal Aneurysm Aorta
DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any which gave rise to the immediate cause stating the underlying cause last
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: 1) Ischemic Heart Disease 2) Chronic Obstructive Pulmonary Disease	27 WAS DECEDENT PREGNANT OR 30 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: John T. Scully MD	29c MEDICAL LICENSE NO: 01017621	29d DATE SIGNED (Month Day Year): July 26, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): John T. Scully MD 8[illegible] Merrillville, In 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Wilkins MD — 32 DATE FILED (Month Day Year): 7/26/99

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.			

FILED APR 2 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

2000 028556

2000 APR 21 AM 11:52 MORRIS W. CARTER RECORDER

FILED FOR RECORD LAKE COUNTY

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE ... HEALTH DEPT

15900

Jackie Cherry
3660 E. 32nd CT.
HOBART, IN. 46342
MAIL TO

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