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. 0932-95 State No. ....

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): KEVIN B. PERES
2. SEX: MALE
3a. TIME OF DEATH: 10:50 PM
3b. DATE OF DEATH (Month Day Yr): APRIL 17, 1995
4. SOCIAL SECURITY NUMBER: 303-68-8254
5a. AGE—Last Birthday (Years): 39
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): March 1, 1956
7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1978
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): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Linda Dommer
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Warehouse Foreman
12b. KIND OF BUSINESS/INDUSTRY: Hosley Internationa
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 7213 Jarnecke Avenue
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): Peter Peres
19. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley Sancya

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Linda R. Peres
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7213 Jarnecke Ave., Hammond, IN 46324
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 20, 1995 St. John Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: James H. Fife
22b. EMBALMER'S LICENSE NO: FD01010795
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John P. Fife
24b. LICENSE NUMBER (of Licensee): FD01020366
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FIFE FUNERAL HOME - FH83001512, 4201 Indpls.Blvd., E.Chgo, IND

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. Hepatorenal syndrome
DUE TO (OR AS A CONSEQUENCE OF)
b. AIDS-associated cholangiopathy
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)

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: acquired immunodeficiency syndrome; Pancreatitis

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): -

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 OF CERTIFIER: B Schmid, MD
29c. MEDICAL LICENSE NO: 30926
29d. DATE SIGNED (Month, Day, Year): APRIL 18, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. BENJAMIN SCHMID, M. D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): April 20, 1995

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.

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

STATE OF INDIANA FILED FOR RECORD 2000 033668 2000 MAY 17 AM 8:10 MORRIS W. CARTER RECORDER

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. APR 20 1995

Alexander S. Williams MD LAKE COUNTY HEALTH COMMISSIONER

FILED MAY 16 2000 PETER BENJAMIN LAKE COUNTY AUDITOR 01615

9.00 Ef. Ti

H/O 92000 1750

Key # 32-90-4 Taylor

Lot 4 + North 1/2 Lot 5 AUKP Buena Vista Add