

ATTENTION ESTATE: Disclosure of the SSN 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. 1239-00
261667

State No.....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

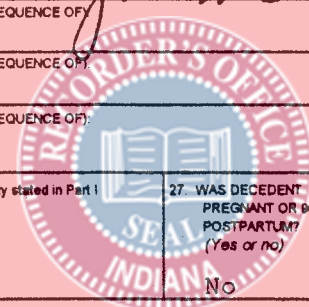
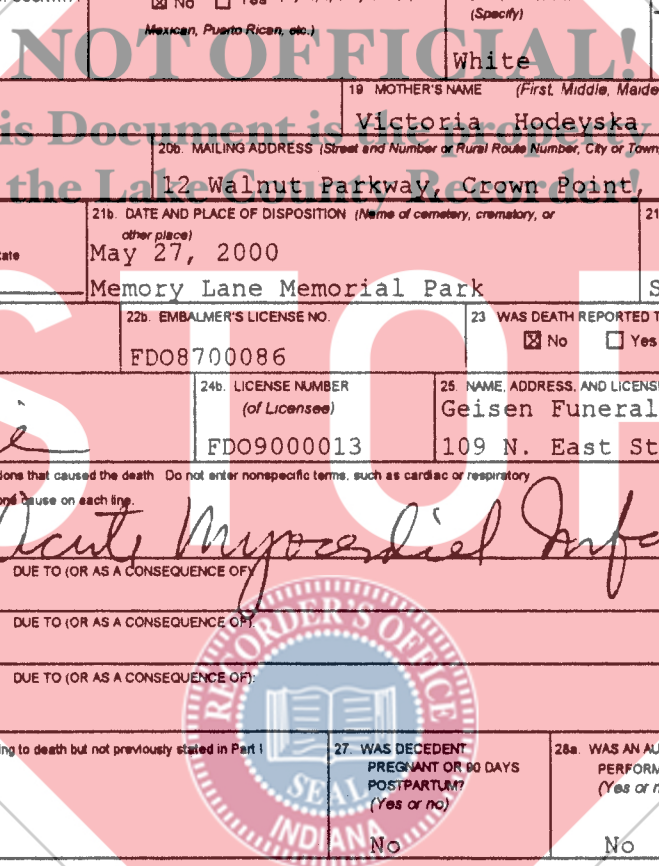
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED - NAME (First, Middle, Last) Louise Kubiak		2. SEX Female		3a. TIME OF DEATH 5:50 AM		3b. DATE OF DEATH (Month, Day, Yr.) May 24, 2000	
4 * SOCIAL SECURITY NUMBER 360-05-9680		5a. AGE - Last Birthday (Years) 86		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:	
6. DATE OF BIRTH (Mo., Day, Yr.) August 20, 1913		7. BIRTHPLACE (City and State or Foreign Country) Chicago Illinois					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		PLACE OF DEATH (Check only one - See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (if not institution, give street and number) St. Anthony Nursing Home				9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (if wife, give maiden name) N/A		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Waitress		12b. KIND OF BUSINESS/INDUSTRY Restaurant	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Crown Point		13d. STREET AND NUMBER 25 Walnut Parkway	
13e. ZIP CODE 46307		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (9-12) College (1-4 or 5+) 6 N/A		18. FATHER'S NAME (First, Middle, Maiden Surname) Victor Bednarek			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Hodeyska		20a. INFORMANT'S NAME (Type/Print) Alfred Kubiak		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Walnut Parkway, Crown Point, IN 46307		20c. Relationship Son	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 27, 2000 Memory Lane Memorial Park		21c. LOCATION - City or Town, State Scherverville, Indiana			
22a. EMBALMER'S NAME Raymond E. White		22b. EMBALMER'S LICENSE NO. FDO8700086		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FDO9000013		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home FH19900060 109 N. East St., Crown Point, Indiana			
28. 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. <u>Acute Myocardial Infarction</u> 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) 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		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. 01039302		29d. DATE SIGNED (Month, Day, year) 5/25/00			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Bernardo S. Lucena M.D., 1221 Indiana Ave., Crown Point 46307							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) MAY 26 2000		33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined			
34a. DATE OF INJURY (Month, Day, Year) JUL 7 2000		34b. TIME OF INJURY 2:00		34c. INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.	
34e. PLACE OF INJURY (Street and Number or Rural Route Number, City or Town, State) PETER BENJAMIN LAKE COUNTY AUDITOR		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MAY 26 2000					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. 00358 <i>Alexander S. Williams M.D.</i> LAKE COUNTY HEALTH COMMISSIONER					



FILED
PETER BENJAMIN
LAKE COUNTY AUDITOR

(4)

25 x 10