

NOTICE: Disclosure of the information we need to pursue our responsibilities is required by law. Failure to provide this information may result in a penalty for non-compliance.

INDIANA STATE DEPARTMENT OF HEALTH

File No. 0008-9.5

CERTIFICATE OF DEATH

State No.

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

REPRINT IN PERMANENT INK

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| 1 DECEASED—NAME (First Middle Last) VIRGINIA R. SIMSTAD | | 2 SEX Female | 3a TIME OF DEATH 8:05 a.m. | 3b DATE OF DEATH (Month Day Yr) January 2, 1995 |
| 4 *SOCIAL SECURITY NUMBER 329-22-9461 | 5a AGE—Last Birthday (Years) 66 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Mo. Day, Yr) February 5, 1928 |
| 7 BIRTHPLACE (City and State or Foreign Country) Calumet City, Illinois | 8a WAS DECEDENT A US VETERAN? no | | | |
| 8b YEAR LAST SERVED IN US ARMED FORCES? --- | 9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) | | | |
| 9b FACILITY NAME (If not institution give street and number) 12710 Grant | 9c CITY TOWN OR LOCATION OF DEATH Crown Point | 9d COUNTY OF DEATH Lake | | |
| 10 MARITAL STATUS (Specify) Married | 11 SURVIVING SPOUSE (If wife give maiden name) Warren K. Simstad | 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 Crown Point | 13d STREET AND NUMBER 12710 Grant | |
| 13e ZIP CODE 46307 | 13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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 |
| 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | 17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 2 | | 18 FATHER'S NAME (First Middle Last) Thomas Bojarski | |
| 19 MOTHER'S NAME (First Middle Maiden Surname) Rose Jachim | | 20a INFORMANT'S NAME (Type/Print) Warren K. Simstad | | |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12710 Grant, Crown Point, IN 46307 | | 20c Relationship Husband | | |
| 21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) January 5, 1995 Calumet Park Cemetery | | 21c LOCATION—City or Town, State Merrillville, Indiana | |
| 22a EMBALMER'S NAME Charles W. Wells | 22b EMBALMER'S LICENSE NO. 1042372 | 23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | | |
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas A. Pruzin</i> | 24b LICENSE NUMBER (of Licensee) 1009893 | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN & LITTLE FUNERAL SERVICE #83001261 811 E. Franciscan Dr., Crown Point, IN 46307 | | |
| 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 (Immediate cause is the disease, injury, or complication that caused the death) DUE TO (OR AS A CONSEQUENCE OF) AUG 18 2000 acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) | | | | Approximate Interval Between Onset and Death 3-4 days |
| 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) --- | | |
| 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>Paul W. Steward M.D.</i> | | 29c MEDICAL LICENSE NO. 111208745 | 29d DATE SIGNED (Month Day, Year) 1/3/95 | |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Paul W. Steward M.D., 1121 South Indiana Ave., Crown Point, IN 46307 | | | | |
| 31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams M.D.</i> | | | 32 DATE FILED (Month Day, Year) January 4, 1995 | |
| 33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide | 34a DATE OF INJURY (Month Day Year) AUG 18 2000 | 34b TIME OF INJURY | 34c INJURY (Yes or no) FILED | 34d DESCRIBE HOW INJURY OCCURRED |
| 34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) AUG 18 2000 | | 34f ADDRESS (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) PETER BENJAMIN LAKE COUNTY AUDITOR 01233 | | |

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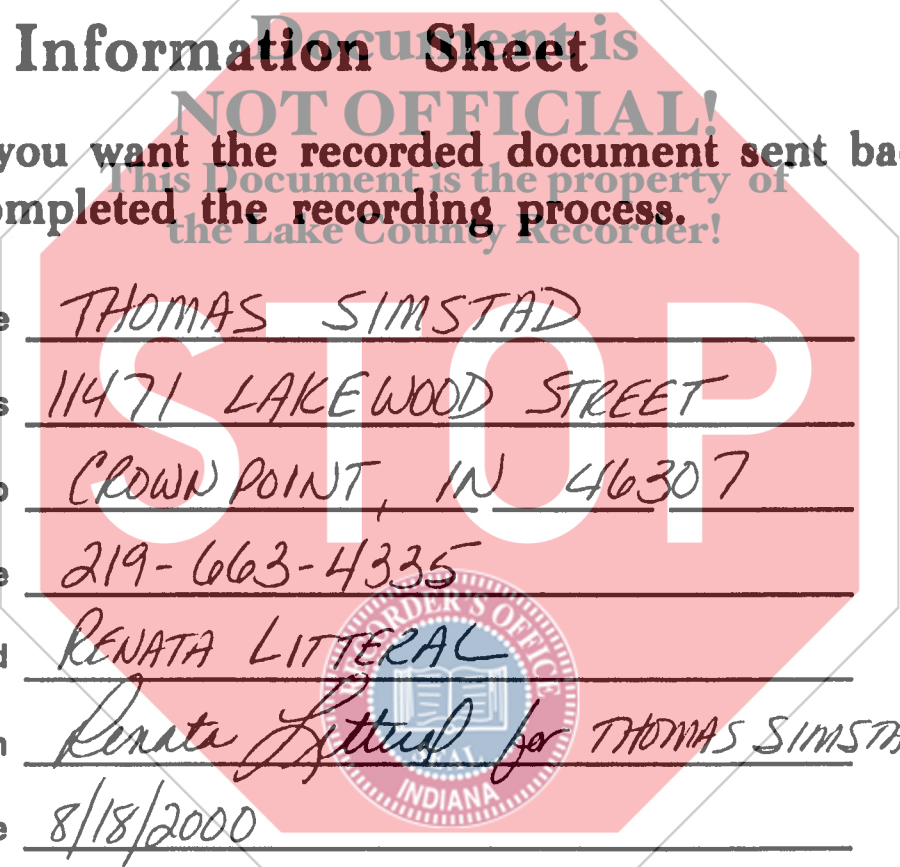
Official Stamp

STATE OF INDIANA
LAKE COUNTY
FILED ROOM

2000 059752 2000 AUG 18 AM 8:48

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Information Sheet**

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Name THOMAS SIMSTAD

Address 11471 LAKEWOOD STREET

City St Zip CROWN POINT, IN 46307

Telephone 219-663-4335

Signature Printed RENATA LITTERAL

Signature Written Renata Litteral for THOMAS SIMSTAD

Date of Signature 8/18/2000

Check Number _____

Check Amount Cash \$ 9.00

Office Use Only

Check Equals Amount Due Yes No

Total _____

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