

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. #28-378-1

Local No. 2134-00

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

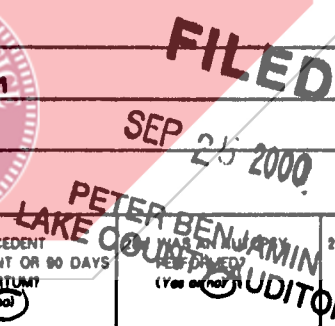
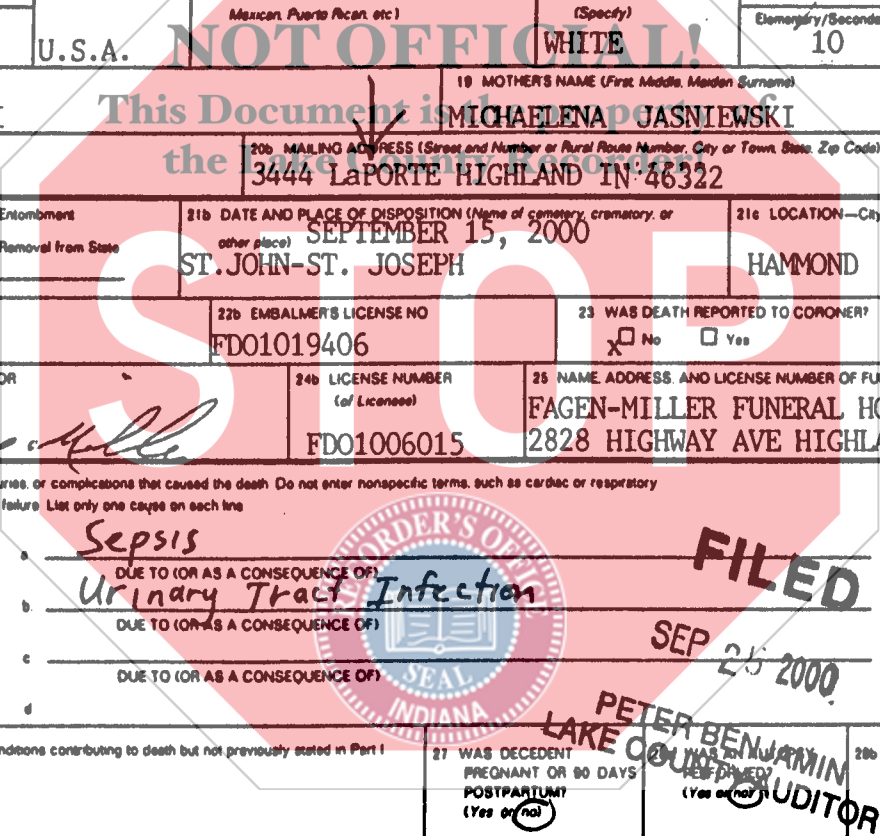
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) LORETTA ELIZABETH NAWROCKI		2 SEX FEMALE		3 TIME OF DEATH 1:00 a.m.		3a DATE OF DEATH (Month, Day, Year) SEPTEMBER 12, 2000	
4 SOCIAL SECURITY NUMBER 311-03-5682		5a AGE—Last Birthday 2009 06 27 89		5b UNDER 1 YEAR Days		5c UNDER 1 DAY Hours Minutes	
6a WAS DECEDENT A U.S. VETERAN? NO		6b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8 DATE OF BIRTH (Mo., Day, Yr.) 2000 JANUARY 9, 1910		7 BIRTHPLACE (City and State or Foreign Country) HAMMOND INDIANA	
9a FACILITY NAME (If not institution, give street and number) 8142 BEECH ST.				9b HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient		9c OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)	
9c CITY, TOWN, OR LOCATION OF DEATH MUNSTER				9d COUNTY OF DEATH LAKE		9e PLACE OF DEATH (Specify only, see instructions)	
10 MARITAL STATUS WIDOWE		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) HOUSEWIFE		12b KIND OF BUSINESS/INDUSTRY OWN HOME	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN, OR LOCATION MUNSTER		13d STREET AND NUMBER 8142 BEECH ST	
13e ZIP CODE 46321		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input 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) 10		18 FATHER'S NAME (First, Middle, Last) MARTIN WITKOWSKI		19 MOTHER'S NAME (First, Middle, Maiden Surname) MICHAELNA JASNIEWSKI	
20a INFORMANT'S NAME (Type/Print) ALICE BARSIC		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3444 LAPORTE HIGHLAND IN 46322				20c Relationship DAUGHTER	
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) SEPTEMBER 15, 2000 ST. JOHN-ST. JOSEPH				21c LOCATION—City or Town, State HAMMOND INDIANA	
22a EMBALMER'S NAME HENERY BLAKE		22b EMBALMER'S LICENSE NO. FDO1019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR		24b LICENSE NUMBER (of Licensee) FDO1006015		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FAGEN-MILLER FUNERAL HOME FH83003035 2828 HIGHWAY AVE HIGHLAND IN 46322			
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. Sepsis					
b. DUE TO (OR AS A CONSEQUENCE OF)		Urinary Tract Infection					
c. DUE TO (OR AS A CONSEQUENCE OF)							
d. DUE TO (OR AS A CONSEQUENCE OF)							
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		28 PETER BENJAMIN LAKE COUNTY HEALTH OFFICER/AUDITOR		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 Med E Fleming MD		29c MEDICAL LICENSE NO. 01029679		29d DATE SIGNED (Month, Day, Year) 9-18-2000	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Rob W. Chicago Ave East Chicago, INDIANA 46312		31 HEALTH OFFICER'S SIGNATURE David A. Fleming MD 9/20/00		32 DATE FILED (Month, Day, Year) September 19, 2000			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State)		34f DESCRIBE HOW INJURY OCCURRED SEP 20 2000			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.					



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