ATTE... ...ing requ... ...ecurity # is ...rsue its ... statutory responsibility ... in order to ... disclosure is ...luntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2262-99   State No. ....

85343

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): JOSEPH G. SEDEY	2 SEX: MALE	3a TIME OF DEATH: 1:45 P.M.	3b DATE OF DEATH (Month Day Yr): DECEMBER 5, 1999	
4 SOCIAL SECURITY NUMBER: 314-26-8110	5a AGE—Last Birthday (Years): 69	5b UNDER 1 YEAR (Months, Days)	5c UNDER 1 DAY (Hours, Minutes)	6 DATE OF BIRTH (Mo. Day Yr): Nov. 28, 1930
7 BIRTHPLACE (City and State or Foreign Country): East Chicago, IN				
8a WAS DECEDENT A U.S. VETERAN?: Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1962	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence		
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): Elizabeth Ferencz	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): School Teacher	12b KIND OF BUSINESS/INDUSTRY: Education	
13a RESIDENCE—STATE: IN	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Munster	13d STREET AND NUMBER: 8732 Linden	
13e ZIP CODE: 46321	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+): 5+				

PARENTS

18 FATHER'S NAME (First, Middle, Last): Joseph Sedey	19 MOTHER'S NAME (First, Middle, Maiden Surname): Antonia N.A.

INFORMANT

20a INFORMANT'S NAME (Type/Print): Elizabeth Sedey	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8732 Linden Munster, IN 46321	20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): December 9, 1999 Elmwood Cemetery	21c LOCATION—City or Town, State: Hammond, IN
22a EMBALMER'S NAME: Jeffery N. Sachs	22b EMBALMER'S LICENSE NO: 29800086	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b LICENSE NUMBER (of Licensee): 1021590	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home##004968 8415 Calumet Munster, IN 46321

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. Metastatic Colon Carcinoma

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:

b. DUE TO (OR AS A CONSEQUENCE OF): End Stage Renal 2° Diabetes

c. DUE TO (OR AS A CONSEQUENCE OF): Renal Transplant

d. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death

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): ---

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: [signature]	29c MEDICAL LICENSE NO: 02000800	29d DATE SIGNED (Month Day Year): DECEMBER 6, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): STEVEN MISCHEL, D.O. 222 DOUGLAS STREET HAMMOND, INDIANA 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD

32 DATE FILED (Month Day Year): December 7, 1999

FILED OCT 10 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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

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