(15) + 2

* **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.

Local No. 537

52 6945

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

July 13, 2001 — Franklin J. Premuda MD — Hammond Health Commission
Date Issued

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Alban R. Dyrke
2. SEX: Male
3a. TIME OF DEATH: 4:10p M
3b. DATE OF DEATH (Month, Day, Yr.): July 10, 2001
4. *SOCIAL SECURITY NUMBER: 325-12-1387
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Jan. 28, 1920
7. BIRTHPLACE (City and State or Foreign Country): Calumet City, IL.
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Hospial North
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name):
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Painter
12b. KIND OF BUSINESS/INDUSTRY: Soap Manufacturin
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 8426 Cline
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS? [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Alexander Dyrke
19. MOTHER'S NAME (First, Middle, Maiden Surname): Amelia Church

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Janice Riordan
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3461 HIghland Ct. Crown Point, IN 46307
20c. Relationship: Niece

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 13, 2001 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, IN.
22a. EMBALMER'S NAME: Raymond E. White Jr.
22b. EMBALMER'S LICENSE NO: FD08700086
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Raymond E White Jr
24b. LICENSE NUMBER (of Licensee): FD08700086
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Chapel Lawn Funeral Home P.O.Box847 Schererville, IN. 463

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. ASPIRATION PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
b. METASTATIC PROSTATIC CA
DUE TO (OR AS A CONSEQUENCE OF):
c. GI BLEEDING
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

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): N/A

FILED
JAN 17 2002
PETER BENEKOS
LAKE COUNTY CORONER

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: Lawrence J. Patnaik, MD
29c. MEDICAL LICENSE NO: 0105441A
29d. DATE SIGNED (Month, Day, Year): 07/11/01

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ST MARGARETS MERCY HOSPITA / LAWRENCE PATNAIK / 5454 HOHMAN (July) AVE HAMMOND, IN.
31. HEALTH OFFICER'S SIGNATURE: Franklin J. Premuda M.D.
32. DATE FILED (Month, Day, Year): July 13, 2001

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): 001167
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

QUEST 2296

SDH06-004 State Form 10110 (R5/1-99)

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