* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 1944-01

128501

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

2002 041548

DECEDENT

1. DECEASED–NAME (First Middle Last): KATHERINE R. KASPRZAK aka KASPER
2. SEX: Female
3a. TIME OF DEATH: 10:40PM
3b. DATE OF DEATH (Month Day Yr): August 30, 2001
4. SOCIAL SECURITY NUMBER: 312-14-2408
5a. AGE - Last Birthday (Years): 93
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): February 9, 1908
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
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 6153 Connecticut Street
9c. CITY TOWN OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
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): Clerk-Cashier
12b. KIND OF BUSINESS INDUSTRY: Grocery
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 455 N. Colorado Street
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 08; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Anthony Lis
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anastasia Popielewski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sylvester Kasprzak
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6153 Connecticut Street, Merrillville, IN 46410
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): September 1, 2001 Calvary Cemetery
21c. LOCATION - City or Town State: Portage, Indiana
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. Cardiac Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Atherosclerotic Cardiovascular Disease
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

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): No

FILED JAN 2 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

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.: 01029381
29d. DATE SIGNED (Month Day Year): 9/4/01
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Deepak Bhojraj MD, 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] D.O.
32. DATE FILED (Month Day Year): September 4, 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

000299
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
SEP 4 2001

9.00 pd
CS

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

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STOP