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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY
HEALTH DEPARTMENT
155 Indiana Ave Suite 104
Valparaiso IN 46383

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): 2002 01478 BABIAK

2. SEX: Male

3a. TIME OF DEATH: 9:53 PM

3b. DATE OF DEATH (Month, Day, Yr.): November 10, 2001

4. SOCIAL SECURITY NUMBER: 282-30-8721

5a. AGE—Last Birthday (Years): 86

5b. UNDER 1 YEAR Months Days

5c. UNDER 1 DAY Hours Minutes

6. DATE OF BIRTH (Mo. Day, Yr.): January 14, 1915

7. BIRTHPLACE (City and State or Foreign Country): Ukraine

8a. WAS DECEDENT A U.S. VETERAN?: No

8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: --

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): Valparaiso Care Center

9c. CITY, TOWN, OR LOCATION OF DEATH: Valparaiso

9d. COUNTY OF DEATH: Porter

10. MARITAL STATUS (Specify): Married

11. SURVIVING SPOUSE (If wife, give maiden name): Sophie Makuchowska

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Rigger

12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel Company

13a. RESIDENCE—STATE: Indiana

13b. COUNTY: Lake

13c. CITY, TOWN, OR LOCATION: Gary

13d. STREET AND NUMBER: 161 East 50th Avenue

13e. ZIP CODE: 46409

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): 8; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Babiak

19. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Medynska

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sophie Babiak

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 161 E 50th Ave, Gary, Indiana 46409

20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 14, 2001 Calumet Park Cemetery

21c. LOCATION—City or Town, State: Merrillville, Indiana

22a. EMBALMER'S NAME: Jonathon R. Christiansen

22b. EMBALMER'S LICENSE NO: FI20100045

23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b. LICENSE NUMBER (of Licensee): 1009893

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

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. Arrhythmia

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF): Sick Sinus Syndrome
c. DUE TO (OR AS A CONSEQUENCE OF):
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: Parkinsons Disease, Ventricular dysfunction, Renal insufficiency, Congestive Heart Failure, Coronary Artery Disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPA... (Yes or no): No

28a. WAS AN AUTOPSY PERFORMED?: No

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): --

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.: 32...

29d. DATE SIGNED (Month, Day, Year): 11/13/01

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Mazurek, 1101 East Glendale Blvd, Valparaiso, IN 46383 (219) 464-9054

31. HEALTH OFFICER'S SIGNATURE: [signature]

32. DATE FILED (Month, Day, Year): November 13 2001

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

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.

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