

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 46-467-35

Key #

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. 999-02

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle, Last) Bruno Benedyk 2002 042667 2 SEX Male 3a TIME OF DEATH 7:40a 3b DATE OF DEATH (Month, Day, Yr.) April 25, 2002

4 *SOCIAL SECURITY NUMBER 309 30 3653 5a AGE—Last Birthday (Years) 72 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Mo, Day, Yr.) Sept. 16, 1929 7 BIRTHPLACE (City and State or Foreign Country) Harrisburg PA

8a WAS DECEDENT A U.S. VETERAN? Yes 8b YEAR LAST SERVED IN U.S. ARMED FORCES 1953 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) Sebo Nursing Home 9c CITY, TOWN, OR LOCATION OF DEATH Hobart IN 9d COUNTY OF DEATH Lake

10 MARITAL STATUS (Specify) Married 11 SURVIVING SPOUSE (If wife, give maiden name) Mary Romeo 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) US Steel Corp Ret. 12b KIND OF BUSINESS/INDUSTRY Steelworker

13a RESIDENCE—STATE Indiana 13b COUNTY Lake 13c CITY, TOWN, OR LOCATION Gary 13d STREET AND NUMBER 3457 Connecticut St.

13e ZIP CODE 46409 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) 12 College (1-4 or 5+) 12

18 FATHER'S NAME (First, Middle, Last) Jacob Benedyk 19 MOTHER'S NAME (First Middle, Maiden Surname) Kate Roznik

20a INFORMANT'S NAME (Type/Print) Mary Benedyk 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3457 Connecticut St. Gary, IN 46409 20c Relationship Wife

21a METHOD OF DISPOSITION Burial Entombment Cremation Removal from State Donation Other (Specify) 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 29, 2002 Calumet Park Cemetery 21c LOCATION—City or Town, State Merrillville, IN 46410

22a EMBALMER'S NAME Anthony S. Rendina Jr 22b EMBALMER'S LICENSE NO. FD01010402 23 WAS DEATH REPORTED TO CORONER? No Yes

24a SIGNATURE OF FUNERAL DIRECTOR Anthony S. Rendina Jr 24b LICENSE NUMBER (of Licensee) FD01010402 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home FH83007819 5100 Cleveland St. Gary, IN 46408

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 Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF) b c d

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Septicemia wound sepsis

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no 28a WAS DEATH REPORTED TO CORONER? (Yes or no) no 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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] M.D. 29c MEDICAL LICENSE NO. 01035576 29d DATE SIGNED (Month, Day, Year) 4/29/02

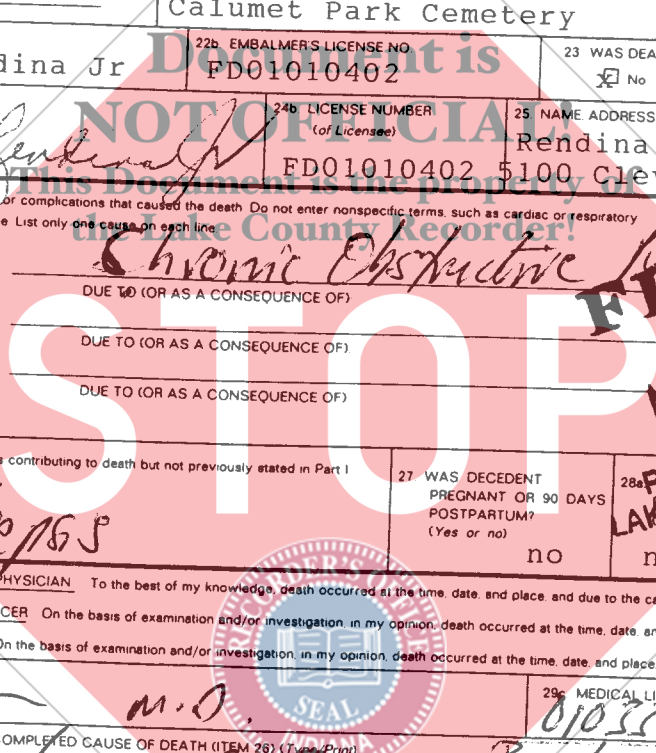
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Orlan N. Nwabara, 5535 Woodbury Ave, Gary, IN 46409

31 HEALTH OFFICER'S SIGNATURE [Signature] Susan W. Best 31b DATE SIGNED (Month, Day, Year) April 29, 2002

33 MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide 34a DATE OF INJURY (Month, Day, Year) APR 30 2007 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) 460557

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



FILED
MAY 07 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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