

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 237301

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

28483  
TYPE/PRINT  
IN  
PERMANENT  
LACK INK

1 DECEASED—NAME (First, Middle, Last) <b>STEVE ROMANAK</b>		2 SEX <b>MALE</b>	3a TIME OF DEATH <b>4:50 P M</b>	3b DATE OF DEATH (Month, Day, Yr.) <b>OCTOBER 22, 2001</b>	
4 *SOCIAL SECURITY NUMBER <b>310-22-36282</b>	5a AGE—Last Birthday (Year) <b>2002</b>	5b UNDER 1 YEAR <b>050800</b>	5c UNDER 1 DAY <b>2002 JUN</b>	6 DATE OF BIRTH (Mo, Day, Yr.) <b>AUGUST 13, 1924</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>EAST CHICAGO, INDIANA</b>	8a WAS DECEDENT A U.S. VETERAN? <b>YES</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <b>MORRIS WILKINSON RECORDERS</b> <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) <b>ST. ANTHONY MEDICAL CENTER</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>CROWN POINT</b>	9d COUNTY OF DEATH <b>LAKE</b>		
10 MARITAL STATUS (Specify) <b>MARRIED</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>LOUISE BIANCHI</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>(RETIRED) MECHANICAL DEPT.</b>		12b KIND OF BUSINESS/INDUSTRY <b>INLAND STEEL</b>	
13a RESIDENCE—STATE <b>INDIANA</b>	13b COUNTY <b>LAKE</b>	13c CITY, TOWN, OR LOCATION <b>CROWN POINT</b>	13d STREET AND NUMBER <b>3647 ST. ANDREWS COURT</b>		
13e ZIP CODE <b>46307</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>WHITE</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) <b>IGNAC JAMES ROMANAK</b>			
19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARIA KOZON</b>		20a INFORMANT'S NAME (Type/Print) <b>LOUISE ROMANAK</b>			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3647 ST. ANDREWS CT., CROWN POINT, IN 46307</b>		20c Relationship <b>WIFE</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>OCT. 26, 2001 N.W. IND. CREMATION SERVICES</b>		21c LOCATION—City or Town, State <b>CROWN POINT INDIANA</b>	
22a EMBALMER'S NAME <b>CRAIG MALONE</b>		22b EMBALMER'S LICENSE NO. <b>1022392</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Resenee P. Burns</i>		24b LICENSE NUMBER (of Licensee) <b>1013890</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BURNS FUNERAL HOME, 10101 BROADWAY CROWN POINT, IN 46307 FDH83002445</b>		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>ADULT RESPIRATORY DISTRESS SYNDROME</b>					
DUE TO (OR AS A CONSEQUENCE OF) <b>FILED</b>					
CONDITIONS WHICH GAVE RISE TO THE IMMEDIATE CAUSE (List with the underlying cause last) <b>OCT 24 2001</b>					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER Of 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. <input type="checkbox"/> CORONER Of 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 <i>[Signature]</i>		29c MEDICAL LICENSE NO. <b>01043633</b>		29d DATE SIGNED (Month, Day, Year) <b>10-23-01</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DR. TOM N. GALOUZIS, 1600 S. LAKE PARK AVE, HOBART, IN SUITE 1102 46342</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Simon W. Best, DO.</i>				32 DATE FILED (Month, Day, Year) <b>October 24, 2001</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			

DECEDENT

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FORMANT

POSITION

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