26-36-154-32

TENTION ESTATE: The Social Security # is) requested by this state agency in order to ue its statutory responsibility. Disclosure is ıtary and there will be no penalty for refusal.

al No. 1364-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

PE/PRINT IN MANENT ACK INK

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	RUDOLPH J. ZAMAROCY
2 SEX	MALE
3a TIME OF DEATH	
3b DATE OF DEATH (Month, Day, Yr)	SEPT. 6, 2002
4 *SOCIAL SECURITY NUMBER	351-16-4272
5a AGE—Last Birthday (Years)	76
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Month, Day, Yr)	2-23-26
7 BIRTHPLACE (City and State or Foreign Country)	IL.
8a WAS DECEDENT A U.S. VETERAN?	NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	
9a PLACE OF DEATH (Check only one)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	MUNSTER COMMUNITY HOSP.
9c CITY, TOWN OR LOCATION OF DEATH	MUNSTER
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name)	GERALDINE
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	SCHEDULING
12b KIND OF BUSINESS/INDUSTRY	STEEL MILL
13a RESIDENCE—STATE	IN.
13b COUNTY	LAKE
13c CITY, TOWN, OR LOCATION	HAMMOND
13d STREET AND NUMBER	4019 HOHMAN AV.
13e ZIP CODE	46320
13f INSIDE CITY LIMITS	☐ No ☑ Yes
13g ON A FARM?	☑ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☑ No ☐ Yes
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+)	
18 FATHER'S NAME (First, Middle, Last)	ALBERT ZAMAROCY
19 MOTHER'S NAME (First, Middle, Maiden Surname)	JULIA SOMMER
20a INFORMANT'S NAME (Type/Print)	GERALDINE ZAMROCY
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4019 HOHMAN AV. HAMMOND, IN.
20c Relationship	WIFE
21a METHOD OF DISPOSITION	☐ Burial ☑ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	SEPT 9, 2002 REGIONAL CREM. SERV.
21c LOCATION—City or Town, State	MUNSTER, IN.
22a EMBALMER'S NAME	N/A
22b EMBALMER'S LICENSE NO.	N/A
23 WAS DEATH REPORTED TO CORONER?	☑ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	1001049
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	OWENS F.H. 300729 816-119TH ST, WHITING, IN.

EDENT / ENTS / RMANT / POSITION

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)
a. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF)
b.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

DUE TO (OR AS A CONSEQUENCE OF)
c.

DUE TO (OR AS A CONSEQUENCE OF)
d.

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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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	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

TIFIER

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO.	29d DATE SIGNED (Month, Day, Year)
Stuart Klein	01031791	9/9/02

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 11355 W. 97th Lane, St. John Ind. Stuart Klein

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Susan W Bert D.O.	September 10, 2002

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Field	Entry
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.	

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

105896

2002 NOV 19 PM 12:14

MORRIS W. CARTER RECORDER

FILED NOV 19 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

0014..

9- [initials]

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

OCT 11 2002

RECORDER'S OFFICE SEAL INDIANA

Document is NOT OFFICIAL
This Document is the property of the Lake County Recorder!
STOP

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