ɔcc (1)

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

ocal No. 1791-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2002 107059

2002 NOV 21 PM 12:19

MORRIS W. CARTER RECORDER

YPE/PRINT IN ERMANENT 3LACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): BERTHA GAYDOS

2 SEX: F

3a TIME OF DEATH: 5:38 P M

3b DATE OF DEATH (Month, Day, Yr): SEPTEMBER 28,2002

4 *SOCIAL SECURITY NUMBER: 313-54-8255

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): 2 25 1915

7 BIRTHPLACE (City and State or Foreign Country): N/A Ohio

8a WAS DECEDENT A US VETERAN?: NO

8b YEAR LAST SERVED IN US ARMED FORCES?: N/A

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b FACILITY NAME (If not institution, give street and number): Methodist Hospital-Southlake Campus

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): N/A

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

12b KIND OF BUSINESS/INDUSTRY: Own Home

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Crown Point

13d STREET AND NUMBER: 638 W. 94th. Ct.

13e ZIP CODE: 46307

13f INSIDE CITY LIMITS: [ ] No [X] Yes

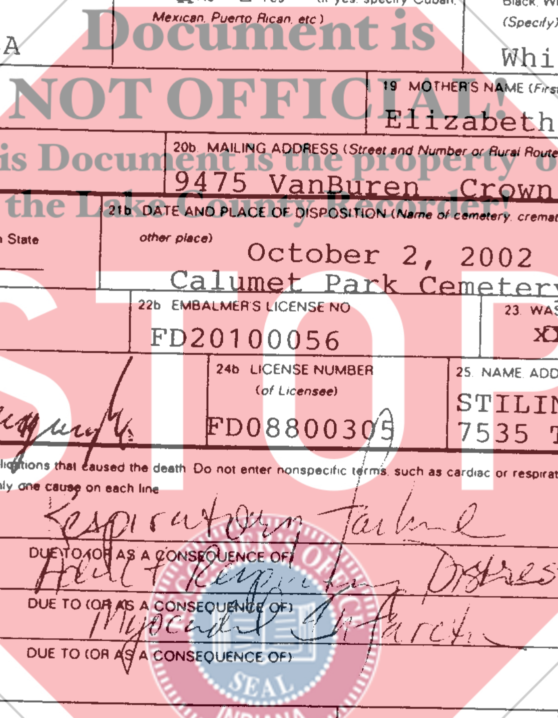
13g ON A FARM?: [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY?: USA

15 WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 10; College (1-4 or 5 +):



ARENTS

18 FATHER'S NAME (First, Middle, Last): George Holtzman

19 MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth N/A

NFORMANT

20a INFORMANT'S NAME (Type/Print): Dorothy Evanseck

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9475 VanBuren Crown Point,IN46307

20c Relationship: Daughter

ISPOSITION

21a METHOD OF DISPOSITION: [X] Entombment [ ] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): October 2, 2002 Calumet Park Cemetery

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

22a EMBALMER'S NAME: Jody Zeese

22b EMBALMER'S LICENSE NO: FD20100056

23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Leonard Greguryk [signature]

24b LICENSE NUMBER (of Licensee): FD08800305

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: STILINOVICH & WIATROLIKFH8300445 7535 Taft St.Merrillville,IN4641

AUSE OF EATH

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. Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF):

b. Adult Respiratory Distress Synd

DUE TO (OR AS A CONSEQUENCE OF):

c. Myocardial Infarction

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

FILED

NOV 21 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

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

COMMUNITY TITLE COMPANY FILE NO 124511

ERTIFIER

29a CERTIFIER (Check only one)

[X] 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: 01035172

29d DATE SIGNED (Month, Day, Year): 10-02-02

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): N. Obaid, M.D. 8895 Broadway Merrillville,IN 46410 219-738-2081

EALTH FFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] D.O.

32 DATE FILED (Month, Day, Year): Oct 7, 2002

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY ... OCT 17 2002

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.

20169.

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