* **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. 198N-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

2002 119190

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): IRENE KOZODYM
2. SEX: FEMALE
3a. TIME OF DEATH: 8:25 Am
3b. DATE OF DEATH (Month, Day, Yr): OCTOBER 24, 2002
4. SOCIAL SECURITY NUMBER: 311 05 4981
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Jun 26 1919
7. BIRTHPLACE (City and State or Foreign Country): East Chicago In
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
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: East Chicago
13d. STREET AND NUMBER: 4226 Olcott Ave
13e. ZIP CODE: 46312
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+):

PARENTS

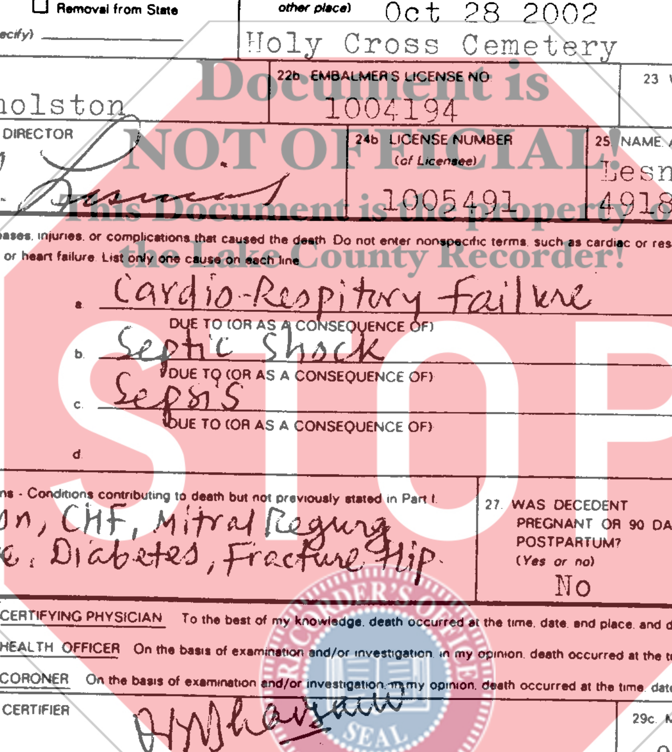
18. FATHER'S NAME (First, Middle, Last): Stanislaw Baut
19. MOTHER'S NAME (First, Middle, Maiden Surname): Stefania Onak

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Kathleen Retseck
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 0481 N 700 W LaPorte In 46350
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Oct 28 2002 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City Il
22a. EMBALMER'S NAME: James W Gholston
22b. EMBALMER'S LICENSE NO.: 1004194
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John B. Lesniak
24b. LICENSE NUMBER (of Licensee): 1005491
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lesniak FH83001601 4918 Magoun E Chicago In 46312



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. Cardio-Respitory failure
DUE TO (OR AS A CONSEQUENCE OF): b. Septic Shock
DUE TO (OR AS A CONSEQUENCE OF): c. Sepsis
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
DEC 23 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Hypertension, CHF, Mitral Regurg, Renal failure, Diabetes, Fracture Hip

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

CERTIFIER

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: B Bhavsar
29c. MEDICAL LICENSE NO.: 01045402
29d. DATE SIGNED (Month, Day, Year): 10/24/2002
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): BHARAT BHAVSAR, M.D. 8731 INDIANAPOLIS BLVD. HIGHLAND, INDIANA 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Best D.O.
32. DATE FILED (Month, Day, Year): 10/28/2002

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.

CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE

Return: Retseck 0481 N. 700 W LaPorte In 46350

9-JJ

001600

TICOR TITLE INSURANCE Crown Point, Indiana

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