

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1814-03

CERTIFICATE OF DEATH

State No. _____

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

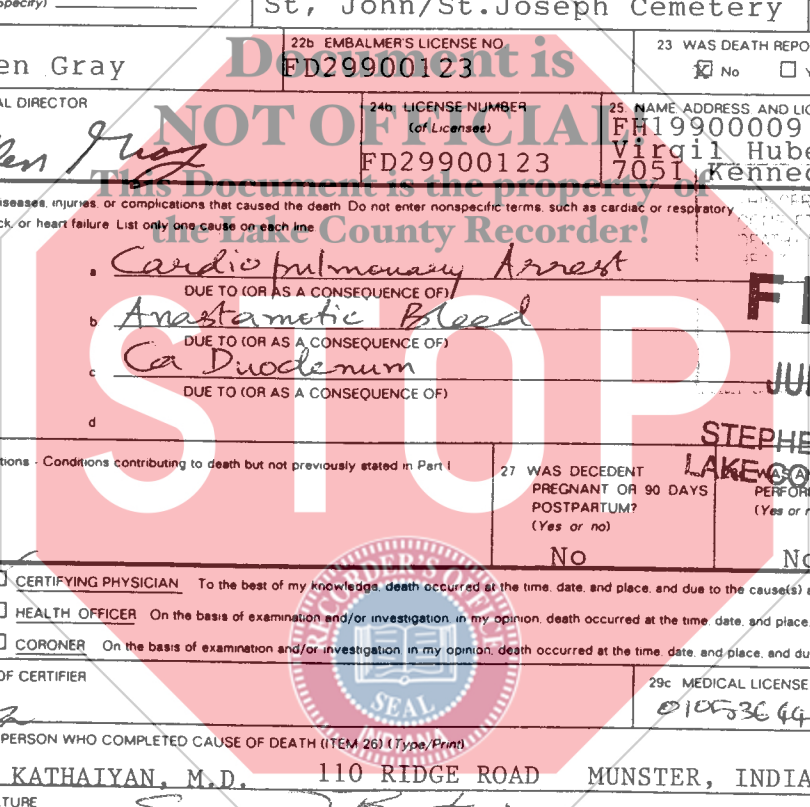
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) DOROTHY Lee GRESKO		2 SEX FEMALE	3a TIME OF DEATH 2:25 A.M.	3b DATE OF DEATH (Month, Day, Yr.) OCTOBER 5, 2002
4 *SOCIAL SECURITY NUMBER 303-54-4759	5a AGE—Last Birthday (Years) 53	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) June 15, 1949
7 BIRTHPLACE (City and State or Foreign Country) McCrorry, AK	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 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> 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) Divorced	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 Domestic
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 7421 McCook Avenue	
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 13		18 FATHER'S NAME (First, Middle, Last) John Richard Armstrong		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Eva Lee Ross		20a INFORMANT'S NAME (Type/Print) Donna L. Blackwell		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7421 McCook Av., Hammond, IN 46323		20c Relationship Daughter		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) October 8, 2002 St. John/St. Joseph Cemetery		21c LOCATION—City or Town, State Hammond, IN
22a EMBALMER'S NAME Henry Allen Gray		22b EMBALMER'S LICENSE NO. FD29900123	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Henry Allen Gray</i>		24b LICENSE NUMBER (of Licensee) FD29900123	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323	
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 pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF) b Anastomatic Bleed DUE TO (OR AS A CONSEQUENCE OF) c Ca Duodenum DUE TO (OR AS A CONSEQUENCE OF) d 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		28 WAS AN AUTOPSY PERFORMED? (Yes or no) No		29 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No
29a CERTIFIER (Check only one) <input 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 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 <input type="checkbox"/> 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 <i>Virgil Huber</i>			29c MEDICAL LICENSE NO. 01053644A	29d DATE SIGNED (Month, Day, Year) 10/8/02
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) UDAYAKUMAR KATHAIYAN, M.D., 110 RIDGE ROAD MUNSTER, INDIANA 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Susan D. East D.O.</i>				32 DATE FILED (Month, Day, Year) October 9, 2002
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED 000436 9.00		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) CK 1630		34g DATE PRONOUNCED DEAD (Month, Day, Year)		
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				



FILED
JUL 7 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

David Weigle + Assoc.

SDH06-004 State Form 10110 (R5/1-99) 5233 Hohman Ave - Hammond IN 46320