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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY
HEALTH DEPARTMENT
155 Indiana Ave Suite 104
Valparaiso IN 46383

21-11-28,29,30,31,32,33,34

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ELIZABETH G. ZOLADZ
2. SEX: Female
3a. TIME OF DEATH: 6:35 PM M
3b. DATE OF DEATH (Month, Day, Yr.): September 10, 2003
4. *SOCIAL SECURITY NUMBER: 322-12-0784
5a. AGE—Last Birthday (Years): 82
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): November 5, 1920
7. BIRTHPLACE (City and State or Foreign Country): Chicago Illinois
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 ☐ Residence ☒ Other (Specify): Hospice
9b. FACILITY NAME (If not institution, give street and number): VNA Hospice Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Porter
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: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 19 Cleveland Avenue
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): Albert Laba, Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Magdelenna Kasprzak

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Carol Kellen
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3625 E. 32nd Ct., Hobart, IN 46342
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Sep 15, 2003 Calvary Cemetery
21c. LOCATION—City or Town, State: Portage IN
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO: FD01006463
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rees Funeral Home, Inc. FH83003069, 600 W. Old Ridge Road, Hobart, IN 46342-0488

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. metastatic cancer to bone, liver — Approximate Interval Between Onset and Death:
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

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

FILED
OCT 3 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

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: P Tara MD
29c. MEDICAL LICENSE NO.: 01031667
29d. DATE SIGNED (Month, Day, Year): 9/15/03

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Pimpa J. Tara MD 8127 Merrillville Road, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary A. Babcock md
32. DATE FILED (Month, Day, Year): Oct 15 2003

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.

000363

Patricia A. Rees
5431 Central Ave
Portage, IN
46368

764B

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