CHICAGO TITLE INSURANCE COMPANY

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND CORRECT COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Date Issued JAN 24, 2003 — Hammond Health Commissioner

Local No. 589

62003333

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Mo. Day Yr.)
Marie	M.	Kowalski	Female	July 9, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months	Days	5c UNDER 1 DAY Hours	Minutes	6 DATE OF BIRTH (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
306-36-7865	51					Aug. 24, 1936	Hammond, Indiana

8 YEAR LAST SERVED IN U.S. ARMED FORCES? No

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)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Margaret Hospital	Hammond	Lake

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Stanley C. Kowalski	Housewife	-

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	East Chicago	4125 Olcott Avenue

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
Yes	No	46312	[X] No [ ] Yes	White	8	-

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
Raymond Powell	Marjorie Brooker

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
Stanley C. Kowalski	4125 Olcott Ave. East Chicago, IN 46312	Husband

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	Jul. 13, 1988 - Holy Cross Cemetery	Calumet City, Illinois

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John P. Fife	1020366	FIFE FUNERAL HOME, INC. - #3001512 4201 Indpls. Blvd., East Chicago, IND

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death	23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title	23b LICENSE NUMBER	23c DATE SIGNED (Month, Day, Year)

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month, Day, Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
9:44 P.M.	July 9, 1988	No

CAUSE OF DEATH

SEE INSTRUCTIONS

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardiac arrest

DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertensive encephalopathy & cerebral edema

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

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

FILED

SEE INSTRUCTIONS

CERTIFIER

29a CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

OCT 9 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
James Greenwald MD	20603	July 12, 1988

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

Dr. J. Greenwald 5454 Hohman Avenue Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE Franklin D. Greenwald M.D.

32 DATE FILED (Month, Day, Year) JUL 13 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined				000788

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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1