CHICAGO TITLE INSURANCE COMPANY

6203105 33 1/2

* 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

CERTIFICATE OF DEATH

Local No. 12/11/01 127599

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

Chicago Title Insurance Company

DECEDENT

- 1 DECEASED—NAME (First, Middle, Last): Bertha B. Sevoiech
- 2 SEX: Female
- 3a TIME OF DEATH: 11:10A M
- 3b DATE OF DEATH (Month, Day, Yr): November 18, 2001
- 4 *SOCIAL SECURITY NUMBER: 339-20-4747
- 5a AGE—Last Birthday (Years): 76
- 5b UNDER 1 YEAR (Months, Days):
- 5c UNDER 1 DAY (Hours, Minutes):
- 6 DATE OF BIRTH (Mo, Day, Yr): Feb. 23,1925
- 7 BIRTHPLACE (City and State or Foreign Country): Chicago, IL
- 8a WAS DECEDENT A U.S. VETERAN?: No
- 8b YEAR LAST SERVED IN U.S. ARMED FORCES?: None
- 9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
- 9b FACILITY NAME (If not institution, give street and number): Munster 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): ---
- 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: IN
- 13b COUNTY: Lake
- 13c CITY, TOWN, OR LOCATION: Hammond
- 13d STREET AND NUMBER: 4414 Ash St.
- 13e ZIP CODE: 46320
- 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

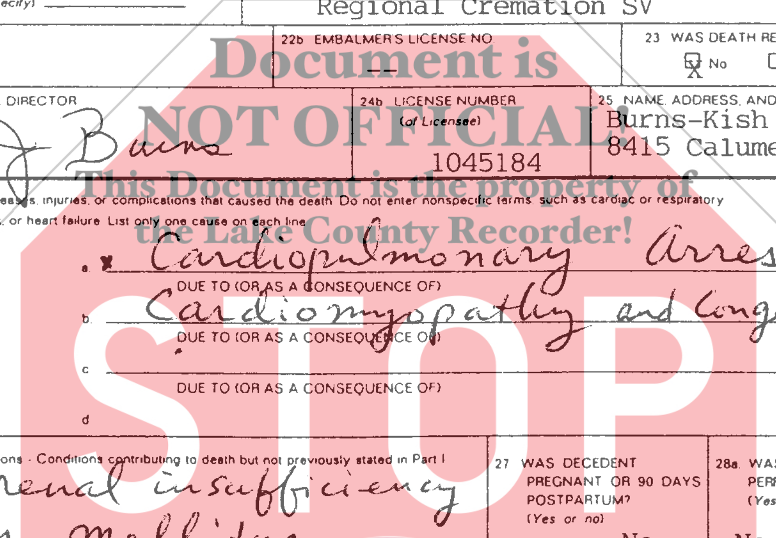
- 18 FATHER'S NAME (First, Middle, Last): N.A. Otyepka
- 19 MOTHER'S NAME (First, Middle, Maiden Surname): Judith N.A.

INFORMANT

- 20a INFORMANT'S NAME (Type/Print): Laverne Torres
- 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1891 W. Carnoustie Pl. Tucson, AZ85737
- 20c Relationship: Niece

DISPOSITION

- 21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
- 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 21, 2001 Regional Cremation SV
- 21c LOCATION—City or Town, State: Munster, IN
- 22a EMBALMER'S NAME: ---
- 22b EMBALMER'S LICENSE NO:
- 23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
- 24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
- 24b LICENSE NUMBER (of Licensee): 1045184
- 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Musnter, IN 46321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STOP

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

- a. Cardiopulmonary Arrest
- b. DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy and Congestive heart failure
- c. DUE TO (OR AS A CONSEQUENCE OF):
- d. DUE TO (OR AS A CONSEQUENCE OF):

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: Chronic renal insufficiency Diabetes Mellitus

- 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):

FILED FEB 5 2004 STEPHEN B. 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: J. Paik, M.D.
- 29c MEDICAL LICENSE NO: 30770
- 29d DATE SIGNED (Month, Day, Year): Nov. 20,2001
- 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Paik, M.D. 200 Monticello Dyer, IN 46311

HEALTH OFFICER

- 31 HEALTH OFFICER'S SIGNATURE: Susan W. Bert D.O.
- 32 DATE FILED (Month, Day, Year): November 20, 2001

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- 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.