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* 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. 72

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Jan 29 2004 — Date Issued

Franklin [signature] — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3 #32-129-31

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): EMILY R. PIVARNIK
2. SEX: FEMALE
3a. TIME OF DEATH: 1:25 A M
3b. DATE OF DEATH (Month, Day, Yr): JANUARY 23, 2004
4. *SOCIAL SECURITY NUMBER: 314-26-6015
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): MARCH 19, 1928
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
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): 914-173rd PLACE
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): WIDOW
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOME MAKER
12b. KIND OF BUSINESS/INDUSTRY: OWN HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 914-173rd PLACE
13e. ZIP CODE: 46324
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 +): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): ALOYSIUS BARAN
19. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE SIWY

INFORMANT

20a. INFORMANT'S NAME (Type/Print): KAREN A. GANZ
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7600 HARVEST DR., SCHERERVILLE, IN. 46375
20c. Relationship: DAUGHTER

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): JANUARY 26, 2004 ST. JOHN CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, INDIANA
22a. EMBALMER'S NAME: DEAN G. WAGNER
22b. EMBALMER'S LICENSE NO.: 8800057
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Dean L. Wag[signature]
24b. LICENSE NUMBER (of Licensee): 8800057
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN-PRUZIN FUNERAL HOME FH83002893 7109 CALUMET AVE., HAMMOND, IN. 46324

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 Ca cancer — Approximate Interval Between Onset and Death: 2 years
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 POSTPARTUM? (Yes or no): no
28a. WAS AN AUTOPSY PERFORMED?: no
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: [signature]
29c. MEDICAL LICENSE NO.: 01040756
29d. DATE SIGNED (Month, Day, Year): JANUARY 27, 2004
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): G. JANO, M.D. 929 RIDGE RD., SUITE 5, MUNSTER, INDIANA 46321 836-2000

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin [signature] M.D.
32. DATE FILED (Month, Day, Year): January 29 2004

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED: 000833
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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

Handwritten in margin: Mary Beth Pivarnik 914-173rd Pl. 46324

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FILED APR 12 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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