

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

State No. 62004997

Local No. 515-041

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) **ADAM J. MYSLIWIEC** 2. SEX **MALE** 3a. TIME OF DEATH **8:10PM** 3b. DATE OF DEATH (Month, Day, Yr) **FEBRUARY 23, 2004**

4. *SOCIAL SECURITY NUMBER **313-01-5288** 5a. AGE—Last Birthday (Years) **93** 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Mo. Day, Yr) **DEC. 10, 1910** 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) **SON'S RESIDENCE**

9b. FACILITY NAME (If not institution, give street and number) **7706 E. 108TH AVENUE** 9c. CITY, TOWN, OR LOCATION OF DEATH **CROWN POINT** 9d. COUNTY OF DEATH **LAKE**

10. MARITAL STATUS **MARRIED** 11. SURVIVING SPOUSE (If not, give maiden name) **ANNE C. VALLEE** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **GLASS BLOWER** 12b. KIND OF BUSINESS/INDUSTRY **AMOCO OIL COMPANY**

13a. RESIDENCE—STATE **INDIANA** 13b. COUNTY **LAKE** 13c. CITY, TOWN, OR LOCATION **HAMMOND (WHITING P.O.)** 13d. STREET AND NUMBER **1613 PARKVIEW AVENUE**

13e. ZIP CODE **46394** 13f. INSIDE CITY LIMITS 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+) **12**

18. FATHER'S NAME (First, Middle, Last) **JOSEPH MYSLIWIEC** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **THEODOSIA UNKNOWN**

20a. INFORMANT'S NAME (Type/Print) **MR. RICHARD MYSLIWIEC** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **7706 E. 108TH, CROWN POINT, IN 46307** 20c. Relationship **SON**

21a. METHOD OF DISPOSITION Burial Entombment Cremation Removal from State Donation Other (Specify) 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **FEBRUARY 27, 2004 HOLY CROSS CEMETERY** 21c. LOCATION—City, Town, State **LAKE COUNTY, ILLINOIS**

22a. EMBALMER'S NAME **HENRY J. BLAKE** 22b. EMBALMER'S LICENSE NO. **FDE01019406** 23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *[Signature]* 24b. LICENSE NUMBER (of Licensee) **FDE01019456** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **BARAN & SON, INC., 1235-119TH, WHITING, IN 46394 EDH83007267**

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. **Atherosclerotic Heart Disease** DUE TO (OR AS A CONSEQUENCE OF): b. c. 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) **N/A** 28a. WERE AUTOPSY FINDINGS PERFORMED? (Yes or no) **NO** 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) **N/A**

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) as stated. **STEPHEN R. STIGLICH LAKE COUNTY AUDITOR**

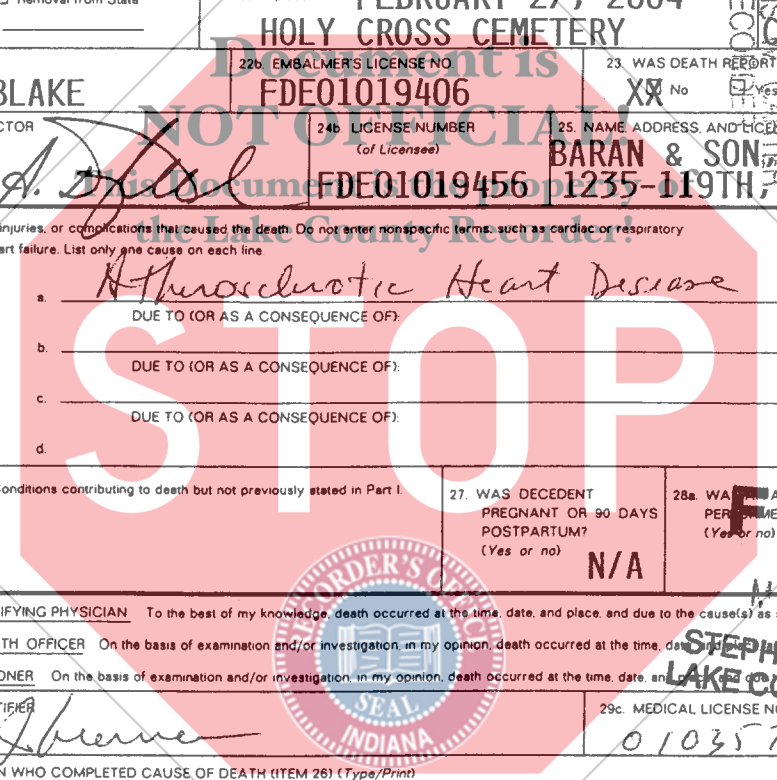
29b. SIGNATURE AND TITLE OF CERTIFIER *[Signature]* 29c. MEDICAL LICENSE NO. **01035700** 29d. DATE (Month, Day, Year) **FEB. 26, 2004**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **MANSUETO SILVERMAN, M.D., 3641 RIDGE ROAD, HIGHLAND, INDIANA 46322**

31. HEALTH OFFICER'S SIGNATURE *[Signature]* 32. DATE FILED (Month, Day, Year) **MAY 7 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. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) **FEB 26 2004**

34g. DATE PRONOUNCED DEAD (Month, Day, Year) 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. **000570**



FILED MAY 7 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR THIS CERTIFIES THE ABOVE MENTIONED CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT FEB 26 2004 000570