OATES & OATES
101 W. 35th Pl.
Merr. 46410

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. 1777-03

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

STATE OF INDIANA
LAKE COUNTY
FILED
AUG 01 2003
RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
ROBERT A. RILEY		MALE	9:15 A M	JULY 24, 2003
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 (Mo. Day. Yr.)
339-18-9691	85			DEC. 24, 1917
7 BIRTHPLACE (City and State or Foreign Country)				
CHICAGO, ILLINOIS				
8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)		
YES	1946	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence	

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
2823 BURGE DR.	CROWN POINT	LAKE

10 MARITAL STATUS (Spouse)	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	JEANETTE A. SEIDA	LOAN SPECIALIST	U.S. GOVERNMENT

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	CROWN POINT	2823 BURGE DR.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
46307	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	WHITE	Elementary/Secondary (0-12)	College (1-4 or 5 +) 5+

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
JAMES ALBERT RILEY	MARGARET G. O'GORMAN

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
JEANETTE A. RILEY	2823 BURGE DR. CROWN POINT, IN. 46307	WIFE

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	JULY 26, 2003 ST. MICHAEL CEMETERY	SCHERERVILLE, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
ELI VUJKO	FD01008300	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Eli Vujko	FD01008300	LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307

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 CEREBROVASCULAR ACCIDENT	
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF)	
	c HYPOTHYROIDISM	
	DUE TO (OR AS A CONSEQUENCE OF)	
	d	

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Robert Kovachevich DO	02002505A	07-25-2003

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
ROBERT KOVACHEVICH, D.O. 9430 WICKER AVE, ST. JOHN, IN 46373

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE
Susan W Best D.O.

32 DATE FILED (Month, Day, Year)
AUG 01, 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.

9.00
KP
769A #5322
#5373

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