

CHICAGO TITLE INSURANCE COMPANY

620046399

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Stat Date Issued: Mar 25, 2004 *Franklin J. Sremuda, M.D.* Hammond Health Commissioner

* 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. 215

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) ADELA F. OVAERT		2 SEX FEMALE		3a TIME OF DEATH 5:40 P. M.		3b DATE OF DEATH (Month, Day, Yr.) MARCH 22, 2004	
4 *SOCIAL SECURITY NUMBER 451-42-3924		5a AGE—Last Birthday (Years) 81		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo. Day, Yr.) OCTOBER 30, 1922		7 BIRTHPLACE (City and State or Foreign Country) ENNIS, TEXAS					
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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 7051 BEECH AVENUE			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) NURSE		12b KIND OF BUSINESS/INDUSTRY BILINGS HOSPITAL	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN, OR LOCATION HAMMOND		13d STREET AND NUMBER 7051 BEECH AVENUE	
13e ZIP CODE 46324		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 15 College (1-4 or 5+) 2		18 FATHER'S NAME (First, Middle, Last) FRANK A. VALEK			
19 MOTHER'S NAME (First, Middle, Maiden Surname) ZDENKA M. MAREK		20a INFORMANT'S NAME (Type/Print) PATRICIA A. OVAERT		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1320-170th ST., HAMMOND, INDIANA 46324			20c Relationship DAUGHTER
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) MARCH 26, 2004 ST. MARY CEMETERY			21c LOCATION—City or Town, State EVERGREEN PARK, ILLINOIS		
22a EMBALMER'S NAME DEAN G. WAGNER		22b EMBALMER'S LICENSE NO. 8800057		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licensee) 8800057		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN-PRUZIN FUNERAL HOME PH83002893 7109 CALUMET AVE., HAMMOND, INDIANA 46324			
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. Obstructive Jaundice DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		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) NO	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Stuart Klein, M.D.</i>		29c MEDICAL LICENSE NO. 01031791A		29d DATE SIGNED (Month, Day, Year) MARCH 25, 2004	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) STUART KLEIN, M.D. 7550 HOHMAN AVENUE MUNSTER, INDIANA 46321		31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Sremuda, M.D.</i>		32 DATE FILED (Month, Day, Year) March 25, 2004			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
34d DESCRIBE HOW INJURY OCCURRED		34a 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) 000257			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					