

#34-252-18

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

FILED 12, 2004  
Date Issued  
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. 536

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) <b>DIANE J. PISOWICZ</b>		2 SEX <b>FEMALE</b>		3a. TIME OF DEATH <b>3:37 P M</b>		3b. DATE OF DEATH (Month, Day, Year) <b>AUGUST 9, 2004</b>	
4. *SOCIAL SECURITY NUMBER <b>306-38-9644</b>		5a. AGE—Last Birthday (Years) <b>65</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) <b>AUGUST 25, 1938</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>EAST CHICAGO, INDIANA</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) <b>ST. MARGARET MERCY HOSPITAL</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>HAMMOND</b>		9d. COUNTY OF DEATH <b>LAKE</b>	
10. MARITAL STATUS (Specify) <b>MARRIED</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>RAYMOND E. PISOWICZ</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>	
13a. RESIDENCE—STATE <b>INDIANA</b>		13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN, OR LOCATION <b>HAMMOND</b>		13d. STREET AND NUMBER <b>4428 PINE AVENUE</b>	
13e. ZIP CODE <b>46327</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>WHITE</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>					
18. FATHER'S NAME (First, Middle, Last) <b>MARTIN F. NEMETH</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JEAN SZEREMETA</b>			
20a. INFORMANT'S NAME (Type/Print) <b>RAYMOND E. PISOWICZ</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4428 PINE AVENUE, HAMMOND, INDIANA 46327</b>		20c. Relationship <b>HUSBAND</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>AUGUST 13, 2004 OAKLAND MEMORY LANES CREMATORY</b>		21c. LOCATION—City or Town, State <b>DOLTON, ILLINOIS</b>			
22a. EMBALMER'S NAME: <b>KEITH D. ANTHONY</b>		22b. EMBALMER'S LICENSE NO. <b>01011911</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b. LICENSE NUMBER (of Licensee) <b>01011911</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>ANTHONY &amp; DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327</b>			
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. <b>Pulmonary Embolus</b> DUE TO (OR AS A CONSEQUENCE OF)					
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. DUE TO (OR AS A CONSEQUENCE OF)					
		c. DUE TO (OR AS A CONSEQUENCE OF)					
		d. DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
27. WAS DECEDENT PREGNANT OR POSTPARTUM? <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>			
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. MEDICAL LICENSE NO. <b>05000618</b>		29c. DATE SIGNED (Month, Day, Year) <b>AUGUST 10, 2004</b>			
29d. SIGNATURE AND TITLE OF CERTIFIER <i>Robert F. Guthrie</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>ROBERT F. GUTHRIE P.O. 6924 INDIANAPOLIS BLVD., HAMMOND, INDIANA 46327</b>					
31. HEALTH OFFICER'S SIGNATURE <i>Robert F. Guthrie</i>		32. DATE FILED (Month, Day, Year) <b>August 12, 2004</b>					
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		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) <b>000121</b>					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>9/8</b>					

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER