ATTENTION ESTATE: The Social Security # is [b]eing requested by this state agency in order to [p]ursue its statutory responsibility. Disclosure is [v]oluntary and there will be no penalty for refusal.

[L]ocal No. 103-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

[T]YPE/PRINT IN [P]ERMANENT [B]LACK INK

[D]ECEDENT

1. DECEASED—NAME (First, Middle, Last): LUELLA A. ORR
2. SEX: FEMALE
3a. TIME OF DEATH: 1:38 A.M.
3b. DATE OF DEATH (Month, Day, Yr.): JANUARY 12, 2005
4. *SOCIAL SECURITY NUMBER: 307-40-6951
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): DECEMBER 28,1939
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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): LEO W. ORR
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: GRIFFITH
13d. STREET AND NUMBER: 1340 N. BROAD STREET
13e. ZIP CODE: 46319
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

[P]ARENTS

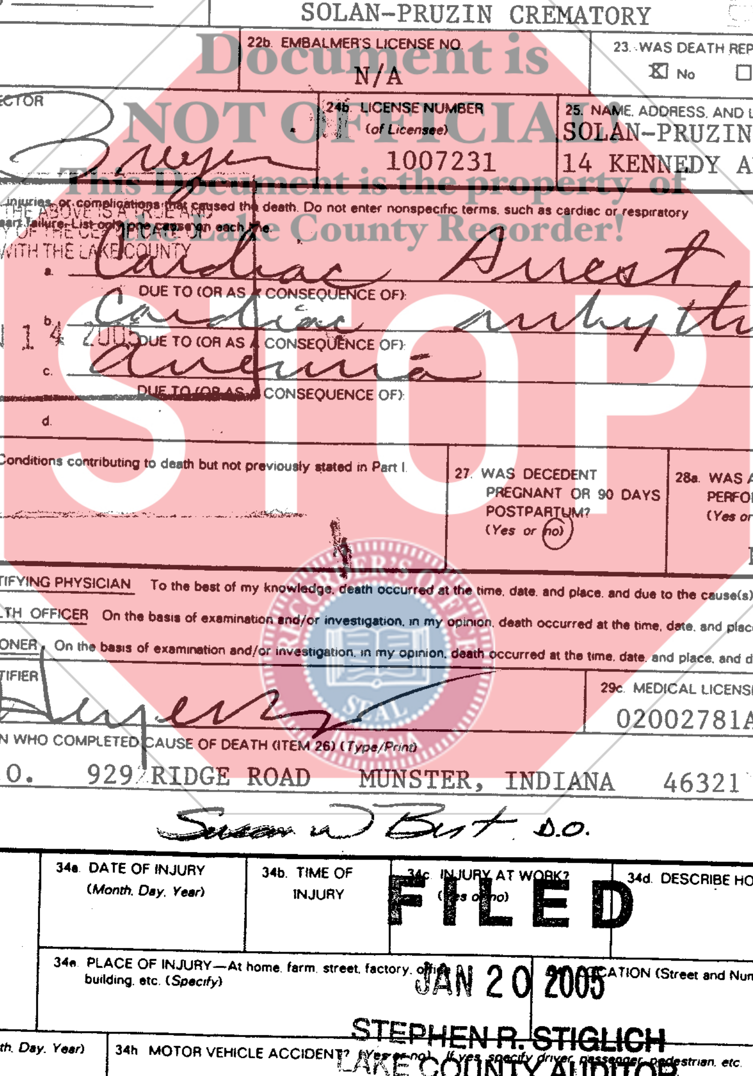
18. FATHER'S NAME (First, Middle, Last): STEVEN KOVACIK
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY SACHA

[I]NFORMANT

20a. INFORMANT'S NAME (Type/Print): LEO W. ORR
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1340 N. BROAD ST., GRIFFITH, INDIANA 46319
20c. Relationship: HUSBAND

[D]ISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JANUARY 14, 2005 SOLAN-PRUZIN CREMATORY
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: NONE
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1007231
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN-PRUZIN FUNERAL HOME FH10200037, 14 KENNEDY AVE., SCHERERVILLE, IN. 46375



[C]AUSE OF [D]EATH

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cardiac Arrest	2 hrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Cardiac arrhythmia	4 mos.
DUE TO (OR AS A CONSEQUENCE OF): c.	Anemia	1 yr.
DUE TO (OR AS A CONSEQUENCE OF): d.		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. JAN 14 2005

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): 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)

[C]ERTIFIER

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.: 02002781A
29d. DATE SIGNED (Month, Day, Year): JANUARY 13, 2005
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOHN HEYER, D.O. 929 RIDGE ROAD MUNSTER, INDIANA 46321

[HE]ALTH [O]FFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W. Bert D.O.
32. DATE FILED (Month, Day, Year): January 14, 2005

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.

FILED
JAN 20 2005
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

000953

Unit #15 Key #26-6-75 S. 60 ft of N 795 ft of E 172 ft of E½ SW NW S. 26 T.36 R.9

Unit #15 Key #26-6-58 S. 65 ft of N 735 ft of 172 ft of E½ SW NW S. 26 T.36 R.9 0.257AC

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