

\* 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

Local No. 3254-96

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

42953  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>GENEVIEVE E. HREHA</b>				2. SEX <b>FEMALE</b>		3a. TIME OF DEATH <b>8:00 P.M.</b>		3b. DATE OF DEATH (Month, Day, Yr) <b>NOVEMBER 18, 1996</b>	
4. *SOCIAL SECURITY NUMBER <b>311-01-8147</b>		5a. AGE—Last Birthday (Years) <b>79</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) <b>May 9, 1917</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>---</b>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <b>8</b> <input type="checkbox"/> Residence				7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>	
9b. FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>			9d. COUNTY OF DEATH <b>LAKE</b>		
10. MARITAL STATUS (Specify) <b>Widowed</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>---</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>Munster</b>			13d. STREET AND NUMBER <b>211 Sycamore Lane</b>		
13e. ZIP CODE <b>46321</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</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>10</b> College (1-4 or 5+) <b>8</b>		18. FATHER'S NAME (First, Middle, Last) <b>Jan Mikos</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eleanora Osika</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Cynthia J. Cunningham</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6745 Nebraska Avenue, Hammond, Indiana 46323</b>			20c. Relationship <b>Daughter</b>		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>November 23, 1996 Chapel Lawn Memorial Gardens</b>			21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>			
22a. EMBALMER'S NAME <b>Thomas G. Pruzin</b>			22b. EMBALMER'S LICENSE NO. <b>1009893</b>			23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) <b>1009893</b>			25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410</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>Congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Acute bacterial endocarditis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Ischemic cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>diabetes mellitus insulin dependent</b> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <b>hypertension Bronchial Asthma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>NOV 21 1996</b> ALEXANDER S. WILLIAMS, M.D.									
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <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>Yes</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. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. MEDICAL LICENSE NO. <b>26494</b>		29d. DATE SIGNED (Month, Day, Year) <b>NOVEMBER 19, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>JUAN TAN, M.D. 9038 COLUMBIA AVENUE, MUNSTER, INDIANA 46321</b>									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) <b>November 21, 1996</b>			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <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)						
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) Yes, specify driver, passenger, pedestrian, etc. <b>001234</b>					

DECEDENT

PARENTS

INFORMANT

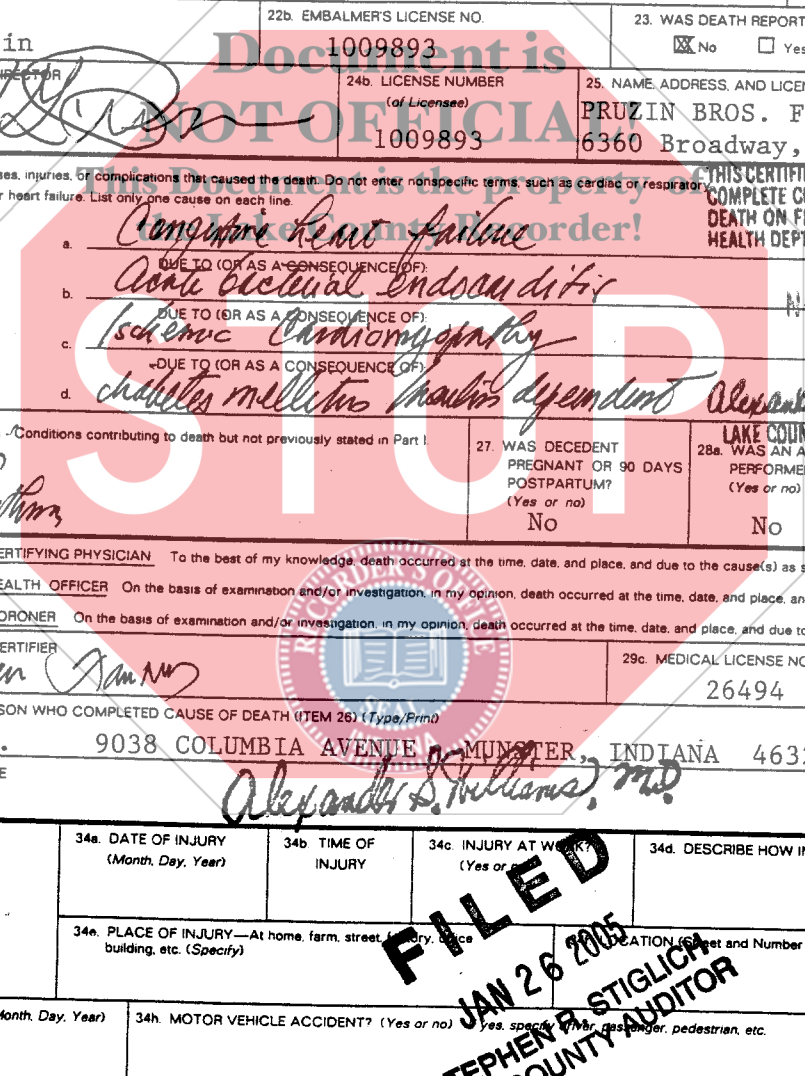
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

TICOR SO 924-9147 28-242-3 (18)



**FILED**  
JAN 26 2005  
STEPHEN R. STIGLICH  
LAKE COUNTY AUDITOR