* **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.

Key # 32-218-9

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

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

Dec 23, 2004 Date Issued — Hammond Health Commissioner

Local No. 857

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

**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.) |
|---|---|---|---|---|
| MIROSLAWA | OPACH | FEMALE | 9:30 AM | DECEMBER 22, 2004 |

| 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) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|---|---|
| 315-74-4324 | 78 | | | | | DEC. 20, 1926 | POLAND |

| 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) |
|---|---|---|
| NO | NONE | HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) — XX Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| 6735 NEW HAMPSHIRE AVENUE | HAMMOND | LAKE |

| 10. MARITAL STATUS (Specify) | 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 |
|---|---|---|---|
| WIDOWED | NONE | HOMEMAKER | OWN HOME |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| INDIANA | LAKE | HAMMOND | 6735 NEW HAMPSHIRE AVENUE |

| 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) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5 + ) |
| 46323 | ☐ No ☒ Yes | ☒ No ☐ Yes | USA | ☒ No ☐ Yes | WHITE | 10 | |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| ADAM PICHOROWSKI | MARIA LOZINSKI |

**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 |
|---|---|---|
| HELEN RICH | 8213 KRAAY AVE, MUNSTER, IN 46321 | DAUGHTER |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| XX Entombment ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | DECEMBER 28, 2004 ST. JOHN - ST. JOSEPH MAUSOLEUM | HAMMOND, INDIANA |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| LARRY D. ANTHONY | 01001447 | ☐ No XX Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Larry D. Anthony | 01001447 | ANTHONY & DZIADOWICZ F.H. #83002916 9445 CALUMET AVE, MUNSTER, IN 46321 |

**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. CARCINOMA BREAST | one year |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | b. DUE TO (OR AS A CONSEQUENCE OF): METASTASIS BREAST CANCER | few months |
| | 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 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) |
|---|---|---|
| NO | NO | NO |

**CERTIFIER**

29a. CERTIFIER (Check only one)

XX 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) |
|---|---|---|
| M. Hussain | 0103445 | DECEMBER 23, 2004 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

MANZOOR HUSSAIN SHAH, M.D. 8032 KENNEDY AVENUE, HIGHLAND, INDIANA 46322

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE — R.R. Kanaar MD

32. DATE FILED (Month, Day, Year) December 23 2004

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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) |
|---|---|
| | 000130 |

| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. |
|---|---|
| | |

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1