

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

State No. ....

Local No. 152

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)<br><b>Stefan Zaja</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                | 2 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                | 3a TIME OF DEATH<br><b>2:40p M</b>                                                                                                                               | 3b. DATE OF DEATH (Month, Day, Yr.)<br><b>May 3, 2005</b>              |                                   |
| 4. *SOCIAL SECURITY NUMBER<br><b>522-42-7374</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5a. AGE—Last Birthday (Years)<br><b>81</b>                                                     | 5b UNDER 1 YEAR<br>Months Days                                                                                                                                                                                                                                                                                      | 5c UNDER 1 DAY<br>Hours Minutes                                                                                                                                  | 6. DATE OF BIRTH (Mo, Day, Yr)<br><b>Sept. 25, 1923</b>                |                                   |
| 7. BIRTHPLACE (City and State or Foreign Country)<br><b>Croatia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                | 8a. WAS DECEDENT A U.S. VETERAN?<br><b>No</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                  |                                                                        |                                   |
| 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                | 9a. PLACE OF DEATH (Check only one. See instructions)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)<br><input checked="" type="checkbox"/> Residence |                                                                                                                                                                  |                                                                        |                                   |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>4724 Carey Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                | 9c. CITY, TOWN, OR LOCATION OF DEATH<br><b>East Chicago</b>                                                                                                                                                                                                                                                         | 9d. COUNTY OF DEATH<br><b>Lake</b>                                                                                                                               |                                                                        |                                   |
| 10. MARITAL STATUS (Specify)<br><b>Married</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. SURVIVING SPOUSE (If wife, give maiden name)<br><b>Gertrude Saller</b>                     | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br><b>Steelworker</b>                                                                                                                                                                                     |                                                                                                                                                                  | 12b. KIND OF BUSINESS/INDUSTRY<br><b>L.T.V. Steel Co.</b>              |                                   |
| 13a. RESIDENCE—STATE<br><b>Indiana</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 13b. COUNTY<br><b>Lake</b>                                                                     | 13c. CITY, TOWN, OR LOCATION<br><b>East Chicago</b>                                                                                                                                                                                                                                                                 | 13d. STREET AND NUMBER<br><b>4724 Carey Street</b>                                                                                                               |                                                                        |                                   |
| 13e. ZIP CODE<br><b>46312</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13f. INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                       | 15. WAS DECEDENT OF HISPANIC ORIGIN?<br><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)<br><b>White</b> |                                   |
| 17. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 18. FATHER'S NAME (First, Middle, Last)<br><b>Mate Zaja</b>                                                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                        |                                   |
| 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Matija</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 20a. INFORMANT'S NAME (Type/Print)<br><b>Gertrude Zaja</b>                                                                                                                                                                                                                                                          |                                                                                                                                                                  |                                                                        |                                   |
| 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4724 Carey St., East Chicago, IND 46312</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 20c. Relationship<br><b>Wife</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                                                  |                                                                        |                                   |
| 21a. METHOD OF DISPOSITION<br><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)<br><b>May 6, 2005<br/>Calumet Park Cemetery</b>                                                                                                                                                                                    |                                                                                                                                                                  | 21c. LOCATION—City or Town, State<br><b>Merrillville, Indiana</b>      |                                   |
| 22a. EMBALMER'S NAME<br><b>James H. Fife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                | 22b. EMBALMER'S LICENSE NO.<br><b>FD01010795</b>                                                                                                                                                                                                                                                                    | 23. WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes                                                        |                                                                        |                                   |
| 24a. SIGNATURE OF FUNERAL DIRECTOR<br><i>John P. Fife</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                | 24b. LICENSE NUMBER (of Licensee)<br><b>FD01020366</b>                                                                                                                                                                                                                                                              | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br><b>FIFE FUNERAL HOME, INC. - FH83001512<br/>4201 Indpls. Blvd., East Chicago, IND</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.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death)<br>a. <b>1. CARCINOMA of lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>2. COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>3. SMOKING</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>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)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no)<br><b>No</b>                                                                                                                                                                                                                                                             | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)<br><b>N/A</b>                                                            |                                                                        |                                   |
| 29a. CERTIFIER (Check only one)<br><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.<br><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.<br><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<br><i>James Cantorna MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                | 29c. MEDICAL LICENSE NO.<br><b>101043716A</b>                                                                                                                                                                                                                                                                       | 29d. DATE SIGNED (Month, Day, Year)<br><b>May 4, 2005</b>                                                                                                        |                                                                        |                                   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br><b>Dr. J. Cantorna - 8437 Kennedy Avenue, Highland, Indiana 46322</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                  |                                                                        |                                   |
| 31. HEALTH OFFICER'S SIGNATURE<br><i>Paula Bernick Atkinson MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                                     | 32. DATE FILED (Month, Day, Year)<br><b>5/5/05</b>                                                                                                               |                                                                        |                                   |
| 33. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident<br><input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                  |                                                                                                | 34a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                              | 34b. TIME OF INJURY                                                                                                                                              | 34c. INJURY AT WORK? (Yes or no)<br><b>FILED</b>                       | 34d. DESCRIBE HOW INJURY OCCURRED |
| 34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)<br><b>JUN - 2 2005</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                | 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>0208</b>                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                        |                                   |
| 34g. DATE PRONOUNCED DEAD (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no)<br><b>STEPHEN R. STIGLICH<br/>LAKE COUNTY AUDITOR</b>                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                        |                                   |