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. 66

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): John Wielgos
2. SEX: Male
3a. TIME OF DEATH: 12:25pm
3b. DATE OF DEATH (Month, Day, Yr): Mar 4 2004
4. *SOCIAL SECURITY NUMBER: 317 14 8055
5a. AGE—Last Birthday (Years): 80
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Jun 9 1923
7. BIRTHPLACE (City and State or Foreign Country): East Chicago In
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1944
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Regency/St Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Single
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance Worker
12b. KIND OF BUSINESS/INDUSTRY: City Park Dept
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 4846 Magoun Ave
13e. ZIP CODE: 46312
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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Steve Wielgos
19. MOTHER'S NAME (First, Middle, Maiden Surname): Tekla Winiarski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Bernice Wielgos
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4846 Magoun E Chicago In 46312
20c. Relationship: Sister

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Mar 8 2004 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City Il
22a. EMBALMER'S NAME: James W Gholston
22b. EMBALMER'S LICENSE NO: 1004194
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1005491
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lesniak FH83001601 4918 Magoun Ave E Chicago In

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Renal failure advanced
DUE TO (OR AS A CONSEQUENCE OF)
b. Congestive Heart failure & Coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Hepatic failure ascites
DUE TO (OR AS A CONSEQUENCE OF)
d. Diabetes Mellitus non insulin dependent

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

Approximate Interval Between Onset and Death

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): No

CERTIFIER

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: 01022957B
29d. DATE SIGNED (Month, Day, Year): 3/6/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Y M Kim Md 4035 Elm St East Chicago In 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Kaykowski
32. DATE FILED (Month, Day, Year): 3/8/04

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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) If yes, specify driver, passenger, pedestrian, etc.

FILED
JUN 13 2005
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR
001078

FILED FOR RECORD

9-7P ck 6723

2005 053383

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