* **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

Dup #15

Local No. 300-05

State No. 25-99-15

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

24-182-9 24-15-57

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Henry Panice Sr.
2. SEX: Male
3a. TIME OF DEATH: 9:45AM
3b. DATE OF DEATH (Month, Day, Yr.): January 31, 2005
4. *SOCIAL SECURITY NUMBER: 331-20-8569
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Oct 5, 1928
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1948
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): 10417 W. 133rd Ave
9c. CITY, TOWN, OR LOCATION OF DEATH: Cedar Lake
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marilyn Barr
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Painter Contract
12b. KIND OF BUSINESS/INDUSTRY: Self-employed
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Cedar Lake
13d. STREET AND NUMBER: 10417 W. 133rd Ave.
13e. ZIP CODE: 46303
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): 8; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Lorenzo Panice
19. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Germano

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Marilyn Panice
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10417 W. 133rd Ave Cedar Lake IN
20c. Relationship: Wife

DISPOSITION

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): February 2, 2005 Calumet Park Crematory
21c. LOCATION—City or Town, State: Cedar Lake, IN
22a. EMBALMER'S NAME: No Embalming
22b. LICENSE NUMBER (of Licensee): NA
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William E. Burdan
24b. LICENSE NUMBER (of Licensee): FD01007697
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burdan Funeral Home FH83002461 12901 Wicker Ave Cedar Lake IN 46303

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): 30 Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF): 5 Chronic Renal Failure.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: 5
DUE TO (OR AS A CONSEQUENCE OF): 5
DUE TO (OR AS A CONSEQUENCE OF): 5

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: 2005

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)

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: DP MD
29c. MEDICAL LICENSE NO.: 01034378A
29d. DATE SIGNED (Month, Day, Year): 2-2-05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): DR. Arshad P. Malik 8560 Broadway Merrillville IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Bast. D.O.
32. DATE FILED (Month, Day, Year): February 2, 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.

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

FEB 02 2005

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