

0545400-Apfx

* 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. 1147-05

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) Dr. Nicholas Egnatz		2 SEX Male	3a TIME OF DEATH 8:20A M	3b DATE OF DEATH (Month, Day, Yr) April 22, 2005
4 *SOCIAL SECURITY NUMBER 304-14-7796	5a AGE—Last Birthday (Years) 89	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) July 31, 1915
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana				
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---		
9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence				
9b FACILITY NAME (If not institution, give street and number) 523 Pinehurst Lane		9c CITY, TOWN, OR LOCATION OF DEATH Schererville		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Louise Rosebrock	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Physician & Surgeon		12b KIND OF BUSINESS/INDUSTRY Private Medical Practice
13a RESIDENCE—STATE Indiana		13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Schererville	
13d STREET AND NUMBER 523 Pinehurst Lane				
13e ZIP CODE 46375	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) White		17 DECEASED'S EDUCATION (Specify only highest grade completed) 5+		
18 FATHER'S NAME (First, Middle, Last) Nicholas Egnatz		19 MOTHER'S NAME (First, Middle, Maiden Surname) Veronica Gzpar		
20a INFORMANT'S NAME (Type/Print) Louise Egnatz		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Pinehurst Schererville, IN 46375		20c Relationship Wife
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) St. John-St. Joseph Cem. Hammond, Ind. April 25, 2005		21c LOCATION—City or Town, State Hammond, Ind.
22a EMBALMER'S NAME James F. Betkowski		22b EMBALMER'S LICENSE NO. FDO9200077		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>James F. Betkowski</i>		24b LICENSE NUMBER (of Licensee) FDO9200077		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Elmwood Chapel FHD#19900052 11300 W. 97th Ln St. John, Ind 46375
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. ACUTE CARDIAC ARREST ACUTE SURVIVAL ANXIETY CONCOMITANT ARTERY DISLAC				
26 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)
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>Charles D. Egnatz MD</i>		
29c MEDICAL LICENSE NO. 01019054		29d DATE SIGNED (Month, Day, Year) 4-24-05		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) C. Egnatz MD 1326 W. US Route 30 Schererville, IN 46375				
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Butcher</i>				32 DATE FILED (Month, Day, Year) April 25, 2005
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year) JUN 29 2005	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. STEPHEN R. STIGLICH LAKE COUNTY AUDITOR		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)		34g DATE PRONOUNCED DEAD (Month, Day, Year) APR 25 2005		
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 1083		34i DATE OF DEATH (Month, Day, Year) APR 25 2005		

Key No. 9-11-22-9

Stewart Title Services of Northwest Indiana The Pointe 5521 W. Lincoln Hwy. Crown Point, IN 46307



LAKE COUNTY RECORDER

9-XP-ST