

* 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

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

James B. Walsh, M.D. Hammond Health Commissioner

Local No. 756

CERTIFICATE OF DEATH

Sept. 30, 1997 Date Issued

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Louis R. Sobak		2 SEX Male		3a TIME OF DEATH 5:34 a		3b DATE OF DEATH (Month, Day, Yr) September 27, 1997	
4 *SOCIAL SECURITY NUMBER 315-30-8918		5a AGE—Last Birthday (Years) 65		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) June 2, 1932		7 BIRTHPLACE (City, and State or Foreign Country) Joliet, Illinois					
8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1955		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy				9c CITY, TOWN, OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Dorothy Cummings		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Millwright		12b KIND OF BUSINESS/INDUSTRY Inland Steel	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Hammond		13d STREET AND NUMBER 44 Roselawn Street	
13e ZIP CODE 46324		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1, 4 or 5 +) 12th					
18 FATHER'S NAME (First, Middle, Last) Louis Widlowski				19 MOTHER'S NAME (First, Middle, Maiden Surname) Anna Gaydos			
20a INFORMANT'S NAME (Type/Print) Dorothy Sobak				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Roselawn St., Hammond, Indiana 46324		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) October 1, 1997 Chapel Lawn Memorial Gardens			21c LOCATION—City or Town, State Scherverville, Indiana		
22a EMBALMER'S NAME Dean G. Wagner		22b EMBALMER'S LICENSE NO. 8800057		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licensee) 8800057		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Solon Funeral Home FH83002893 7109 Calumet Ave. Hammond, In. 46324			
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. Sudden cardiac death syndrome DUE TO (OR AS A CONSEQUENCE OF) b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I							
27 WAS DECEDENT PREGNANT AT DEATH? (Yes or no) NO		28 WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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>James B. Walsh</i>				29c MEDICAL LICENSE NO. 01027487		29d DATE SIGNED (Month, Day, Year) 9/28/97	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEN 26) (Type/Print) <i>James B. Walsh, 5509 Nehman, Hammond, IN 46320</i> (September)							
31 HEALTH OFFICER'S SIGNATURE <i>James B. Walsh, M.D.</i>						32 DATE FILED (Month, Day, Year) September 30, 1997	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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)			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <i>02534</i>					