

ATTENTION ESTATE: The Social Security # is requested by this state agency in order to sue 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. 4015-05

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

PE/PRINT IN PERMANENT INK

DECEDENT

MENTS

FORMANT

POSITION

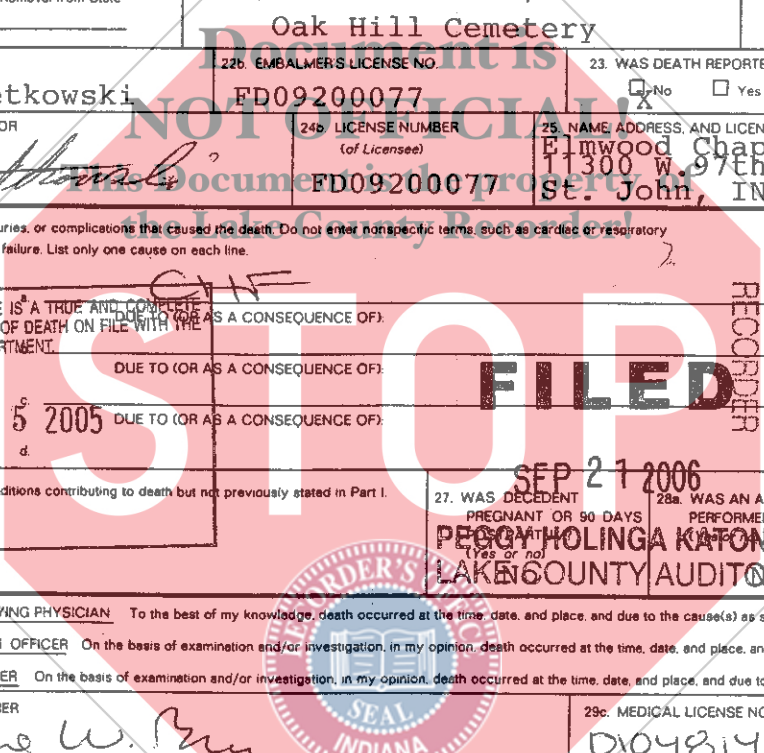
USE OF

ITIFIER

ALTHICER

1. DECEASED—NAME (First, Middle, Last) Bessie Ivancovich		2. SEX Female	3a. TIME OF DEATH 12:53 P	3b. DATE OF DEATH (Month, Day, Yr.) December 2, 2005
4. *SOCIAL SECURITY NUMBER 336-12-8782	5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) March 2, 1924
7. BIRTHPLACE (City and State or Foreign Country) Kewanee, IL	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 OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) 1553 W. 98th Pl.		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) None	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Book Keeper		12b. KIND OF BUSINESS/INDUSTRY Pullman Bank
13a. RESIDENCE—STATE IN	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Crown Point		13d. STREET AND NUMBER 1553 W. 98th Pl.
13e. ZIP CODE 46307	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 1006		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) Mile Jaksich			19. MOTHER'S NAME (First, Middle, Maiden Surname) Dragina Yovich	
20a. INFORMANT'S NAME (Type/Print) Elizabeth Henrycy		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Sheffield Lot 27 Hammond, IN 46320		20c. Relationship Daughter
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) December 7, 2005 Oak Hill Cemetery		21c. LOCATION—City or Town, State Hammond, IN
22a. EMBALMER'S NAME James F. Betkowski		22b. EMBALMER'S LICENSE NO. FD09200077		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Betkowski</i>		24b. LICENSE NUMBER (of Licensee) FD09200077		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Elmwood Chapel FHD#19900052 11300 W. 97th Ln. St. John, IN 47373
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) CERTIFIES THE ABOVE IS A TRUE AND COMPLETE STATEMENT OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DEC 05 2005				
PART II. Other significant conditions: Conditions contributing to death but not previously stated in Part I.				
27. WAS DECEDENT PREGNANT OR 90 DAYS BEFORE DEATH? NO		28a. WAS AN AUTOPSY PERFORMED? NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
29a. CERTIFIER (Check only one) <input 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>Theodore W. Burt</i>			29c. MEDICAL LICENSE NO. D10648142	29d. DATE SIGNED (Month, Day, Year) 12/5/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 297 W. FRANCISCAN LN Ste 203 Crown Point IN 46307				
31. HEALTH OFFICER'S SIGNATURE <i>Susan W Burt D.O.</i>				32. DATE FILED (Month, Day, Year) December 5, 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"/> Could not be Determined <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 11-7 TP		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) 018771
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. TI		

33-23-142-48
920067197
TICOR HD



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MICHAEL A. BROWN
RECORDER
SEP 25 AM 9:19
APPROXIMATE Interval Between Onset and Death
11-7
TP
TI