* 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. 95-321

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Acc # 20-178-11

City of East Chicago
East Chicago, In 46312

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Evelyn M. Drapac
2. SEX: Female
3a. TIME OF DEATH: 11:30PM
3b. DATE OF DEATH (Month, Day, Yr.): Nov. 5, 1995
4. *SOCIAL SECURITY NUMBER: 312-18-2911
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): Feb.12,1923
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, IN.
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Anthony Drapac
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Secretary
12b. KIND OF BUSINESS/INDUSTRY: Rivet Manufacturin
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 4928 Homerlee Avenue
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): Wilhem Trzcinski
19. MOTHER'S NAME (First, Middle, Maiden Surname): Not Available

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Anthony Drapac
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4928 Homerlee,East Chicago,IN46312
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 9, 1995 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, IN.
22a. EMBALMER'S NAME: James W. Gholston
22b. EMBALMER'S LICENSE NO.: 1004194
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John B. Lesniak
24b. LICENSE NUMBER (of Licensee): 1005491
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lesniak FH8300160 1 4918 Magoun,E.Chicago,IN.46312

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. Advanced non small cell lung cancer
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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.: Diabetes Mellitus
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):

CERTIFIER

29a. CERTIFIER (Check only one): [X] 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.: 29782
29d. DATE SIGNED (Month, Day, Year): 11-7-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M. Y. Ali,1630 West 45th Avenue, Munster, IN. 46321.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Ruzkovich
32. DATE FILED (Month, Day, Year): 11-8-95

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 Rural Route Number, City or Town, State):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Specify driver, passenger, pedestrian, etc.)

11-ZP CS

2006 083700

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2006 SEP 25 AM 9:43

MICHAEL A. BROWN RECORDER

FILED SEP 25 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

018940

IVRA-20 (7/05)

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

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT