* **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. 773

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Nov. 29, 2005 — Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	CHESTER PTAK
2. Sex	MALE
3a. Time of Death	3:45 AM
3b. Date of Death (Month, Day, Yr)	NOVEMBER 28, 2005
4. *Social Security Number	316-36-5272
5a. Age—Last Birthday (Years)	85
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	JANUARY 6, 1920
7. Birthplace (City and State or Foreign Country)	POLAND
8a. Was Decedent a U.S. Veteran?	NO
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	HAMMOND-WHITING CARE CENTER
9c. City, Town, or Location of Death	HAMMOND/WHITING P.O.
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)	OPERATOR
12b. Kind of Business/Industry	STEEL
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town, or Location	HAMMOND
13d. Street and Number	3746 HENRY AVENUE
13e. Zip Code	46327
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+)	12

PARENTS

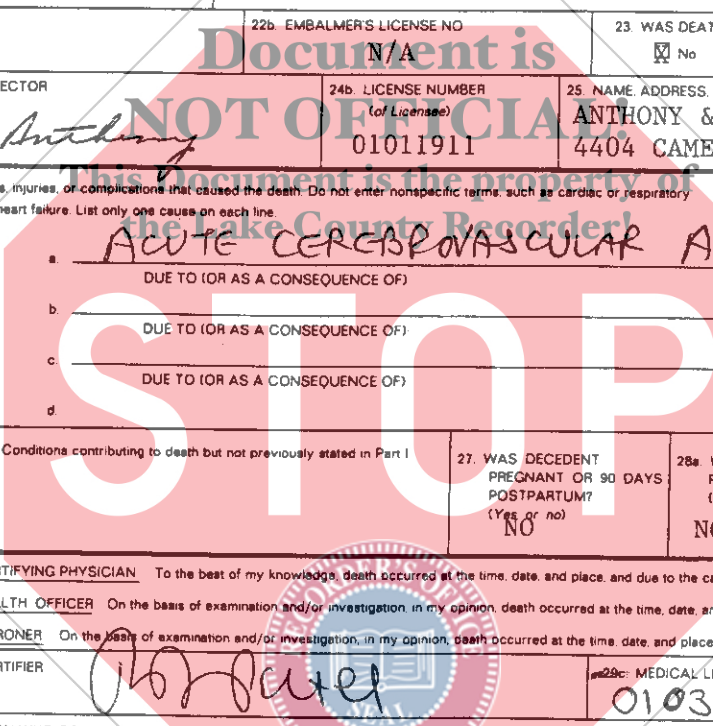
Field	Entry
18. Father's Name (First, Middle, Last)	UNAVAILABLE
19. Mother's Name (First, Middle, Maiden Surname)	UNAVAILABLE

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	DONNA BARBEE
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1168 SIDONIA COURT, ENCINITAS, CA 92024
20c. Relationship	DAUGHTER

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	DECEMBER 2, 2005 HOLY CROSS CEMETERY
21c. Location—City or Town, State	CALUMET CITY, ILLINOIS
22a. Embalmer's Name	N/A
22b. Embalmer's License No.	N/A
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	Keith D Anthony
24b. License Number (of Licensee)	01011911
25. Name, Address, and License Number of Funeral Home	ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, IN 46327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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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	ACUTE CEREBROVASCULAR ACCIDENT	10 DAYS
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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

Field	Entry
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)	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.

Field	Entry
29b. Signature and Title of Certifier	[signature]
29c. Medical License No.	01034865
29d. Date Signed (Month, Day, Year)	NOVEMBER 29, 2005
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	M. PATEL M.D. 835 - 169TH STREET, HAMMOND, INDIANA 46324

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	R Ramana MD
32. Date Filed (Month, Day, Year)	November 29 2005
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 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.	

FILED OCT 11 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

020491

COMMUNITY TITLE COMPANY FILE NO. 35727

Douglas Park Manor Resub of Lots 13 to 25 Block 7 Lot D 26-33-0212-0004

11 PP CM

SDH06-004 State Form 10110 (R5/1-99)