

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 1120-05

State No.....

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

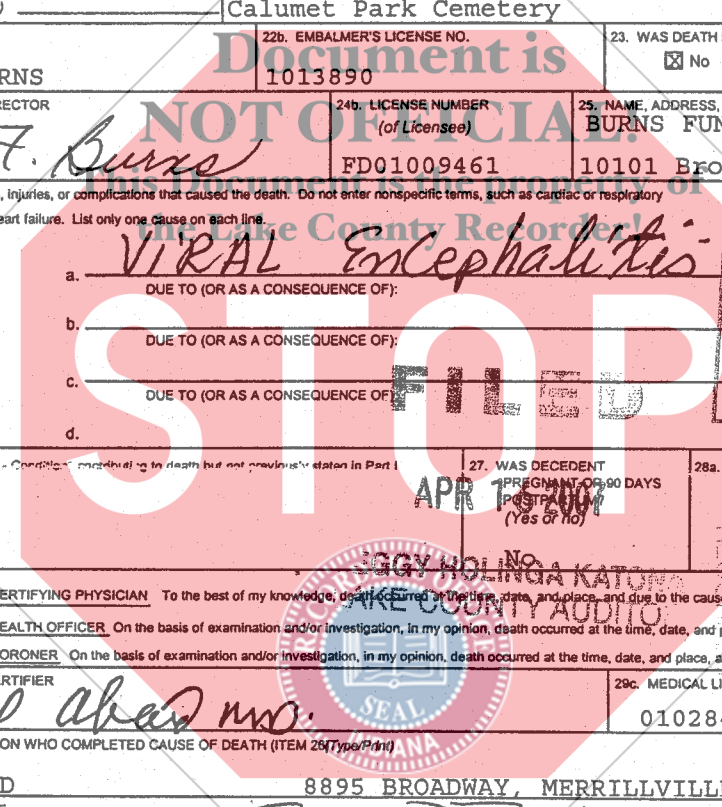
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) JOHN MEZMARICK		2. SEX Male		3a. TIME OF DEATH 12:40 AM		3b. DATE OF DEATH (Month, Day, Yr.) April 18, 2005	
4. *SOCIAL SECURITY NUMBER 316-22-9506		5a. AGE - Last Birthday (Years) 77		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:	
6. DATE OF BIRTH (Mo., Day, Yr.) November 03, 1927		7. BIRTHPLACE (City and State or Foreign Country) GARY Indiana					
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1948		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) METHODIST HOSPITAL				9c. CITY, TOWN, OR LOCATION OF DEATH MERRILLVILLE		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) MARILYN KOBALSKI		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) TEAMSTER & ELECTRICIAN		12b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION CROWN POINT		13d. STREET AND NUMBER 1235 WESTBROOK CT.	
13e. ZIP CODE 46307		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) Elementary/Secondary (0-12): 12 College (1-4 or 5-):				18. FATHER'S NAME (First, Middle, Last) IVAN MEZMARICK	
19. MOTHER'S NAME (First, Middle, Maiden Surname) STEFANIA ZLATER		20a. INFORMANT'S NAME (Type/Print) MARILYN MEZMARICK		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 WESTBROOK CT., CROWN POINT, IN		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) April 21, 2005 Calumet Park Cemetery		21c. LOCATION - City or Town, State Merrillville, Indiana			
22a. EMBALMER'S NAME TERRENCE P. BURNS		22b. EMBALMER'S LICENSE NO. 1013890		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana			
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) VIRAL Encephalitis DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Conditions, if any, which gave rise to the immediate cause stating the underlying cause last		27. WAS DECEASED PREGNANT 90-99 DAYS PRIOR TO DEATH? (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) N/A	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred on 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>Suzanne A. Nazzal M.D.</i>		29c. MEDICAL LICENSE NO. 01028410		29d. DATE SIGNED (Month, Day, Year) 4-20-05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. NAZZAL OBAID 8895 BROADWAY, MERRILLVILLE, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Suzanne W. Burt, D.O.</i>				32. DATE FILED (Month, Day, Year) April 20, 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		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) April 18, 2005		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.					

Parcel # 23-91-507-10



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
MAY 4 2005

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