

153726

City Of East Chicago
East Chicago, In 46312

* 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

CERTIFICATE OF DEATH

State No.

Local No. 76

#677724 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) ANNE MARIE VARTCHAK				2. SEX Female		3a. TIME OF DEATH 2:00p		3b. DATE OF DEATH (Month, Day, Yr.) February 5, 2005				
4. *SOCIAL SECURITY NUMBER 303-56-8039			5a. AGE—Last Birthday (Years) 56		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) June 12, 1948		7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	
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 <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) Regency 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) Michael Varichak			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife			12b. KIND OF BUSINESS/INDUSTRY			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Griffith			13d. STREET AND NUMBER 218 N. Jay					
13e. ZIP CODE 46319		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
18. FATHER'S NAME (First, Middle, Last) George Stark						19. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Rick						
20a. INFORMANT'S NAME (Type/Print) Michael Varichak				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 N. Jay Griffith, In 46319				20c. Relationship Husband				
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <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) May 9, 2005 Graceland Cemetery				21c. LOCATION—City or Town, State Valparaiso, Ind.				
22a. EMBALMER'S NAME Anthony S. Rendina Jr.				22b. EMBALMER'S LICENSE NO. FD01010402				23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr.</i>				24b. LICENSE NUMBER (of Licensee) FD01010402		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home FH83007819 5100 Cleveland St. Gary, In46408						
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. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF) b. CARDIOMYOPATHY 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										Approximate Interval Between Onset and Death FILED MAY 29 2007		
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No						28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b. HAD THE AUTOPSY BEING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR				
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 WALD M.D.						29c. MEDICAL LICENSE NO. 01039547		29d. DATE SIGNED (Month, Day, Year) 2/7/05				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Chitbaranjan A. Patel 2075 Ends Blvd Whiting In 46394												
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy R. Kovach M.D.</i>										32. DATE FILED (Month, Day, Year) 2-7-05		
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) 2/5/05		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED 006958 CS CA			
34a. 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) 2/7/05						34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						

Original Town
lots 15+16 Block 11
15-26-0131-0015

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