

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 943-01
993744

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

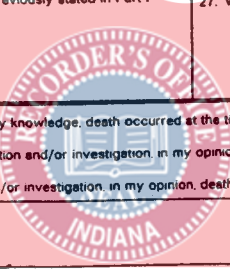
CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Frances S. Dybel				2. SEX Female	3a. TIME OF DEATH 10:30A M	3b. DATE OF DEATH (Month, Day, Yr) April 12, 2001	
4. SOCIAL SECURITY NUMBER 310-18-9708		5a. AGE—Last Birthday (Years) 80	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) Feb. 5, 1921		7. BIRTHPLACE (City and State or Foreign Country) East Chicago, IN
8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None		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) 1930 Melbrook Ct.				9c. CITY, TOWN, OR LOCATION OF DEATH Munster		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Joseph Dybel		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Home	
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Munster		13d. STREET AND NUMBER 1930 Melbrook Ct.	
13e. ZIP CODE 46321	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEASED 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) Vincent Sajdyk				19. MOTHER'S NAME (First, Middle, Maiden Surname) Balbina N.A.			
20a. INFORMANT'S NAME (Type/Print) Joseph Dybel				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1930 Melbrook Ct. Munster, IN 46321		20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) April 17, 2001 Holy Cross Cemetery			21c. LOCATION (City or Town, State) Calumet City, IL		
22a. EMBALMER'S NAME Brian T. Burns		22b. EMBALMER'S LICENSE NO. 8601763		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) 1021590		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321			
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 OF DEATH (THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH ON FILE WITH THE COUNTY HEALTH DEPARTMENT.) a. Stroke DUE TO (OR AS A CONSEQUENCE OF): Chronic Brain Syndrome b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 1 year							
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I				27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	
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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. 01029887		29d. DATE SIGNED (Month, Day, Year) April 12, 2001	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) A. Gandhi, M.D. 9122 Columbia Munster, IN 46321							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) April 17, 2001			
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) MAY 31 2007		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no) MAY 31 2007	
		34d. DESCRIBE HOW INJURY OCCURRED \$11		34e. PLACE OF INJURY—At home, farm, business, etc. (Specify) PEGGY HOLLINGA KATONA LAKE COUNTY AUDITOR			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 007126			

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