

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to insure 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. 2409-06

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

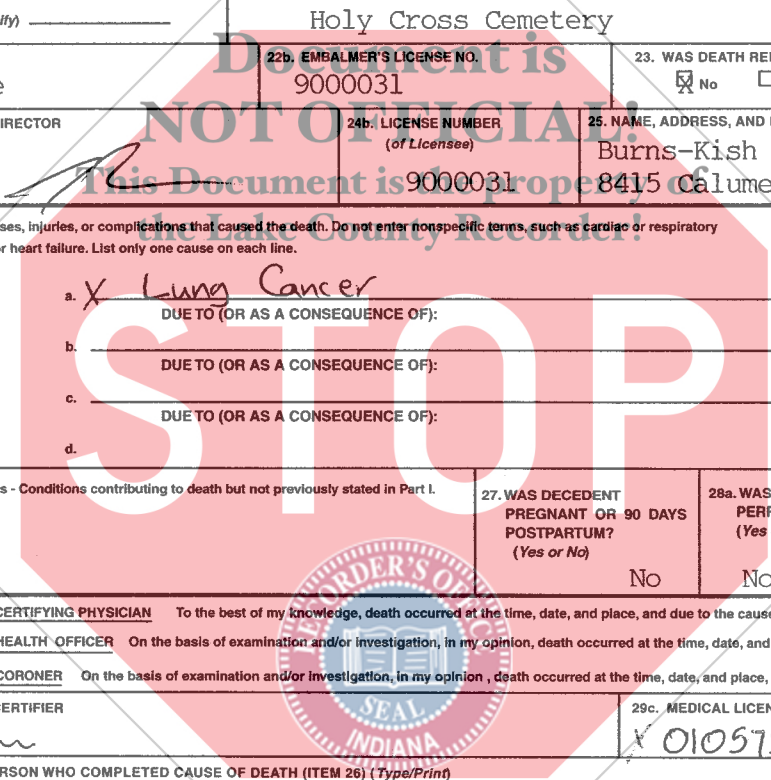
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) Joseph Dybel			2. SEX Male	3a. TIME OF DEATH 6:10P M	3b. DATE OF DEATH (Month, Day, Year) October 4, 2006
4. *SOCIAL SECURITY NUMBER 309-16-8088	5a. AGE - Last Birthday (Years) 90	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) Aug. 9, 1916	7. BIRTHPLACE (City and State or Foreign Country)
8a. WAS DECEASENT 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 type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) Dyer Nursing & Rehabilitation			9c. CITY, TOWN, OR LOCATION OF DEATH Dyer		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) ---	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Lab Tech		12b. KIND OF BUSINESS/INDUSTRY AMOCO/oil	
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? USA	15. WAS DECEASENT 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 +)
18. FATHER'S NAME (First, Middle, Last) Joseph Dybel			19. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Drazek		
20a. INFORMANT'S NAME (Type/Print) Terrence 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 Son	
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) October 9, 2006 Holy Cross Cemetery		21c. LOCATION - City or Town, State Calumet City, IL	
22a. EMBALMER'S NAME: John T. Noble		22b. EMBALMER'S LICENSE NO. 9000031		23. WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR		24b. LICENSE NUMBER (of Licensee) 9000031		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. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <input checked="" type="checkbox"/> 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 Unknown.					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.					
27. WAS DECEASENT 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)	
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 L. Gandhi				29c. MEDICAL LICENSE NO. 01057594A	
29d. DATE SIGNED (Month, Day, Year) Oct. 5, 2006					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) L. Gandhi, MD 2727 Highway Ave. Highland, IN 46322					
31. HEALTH OFFICER'S SIGNATURE Peggy Holinga Katona					
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) MAY 31 2007	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or No)	34d. LOCATION (Street and Number or Rural Route Number, City or Town, State) Peggy Holinga Katona Lake County Auditor
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34e. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.			



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FILED

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE DEATH RECORD AS FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT. OCT 11 2006 \$11 TV CA

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