

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to ensure 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. 695-07

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

#711842  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

MENTS

FORMANT

POSITION

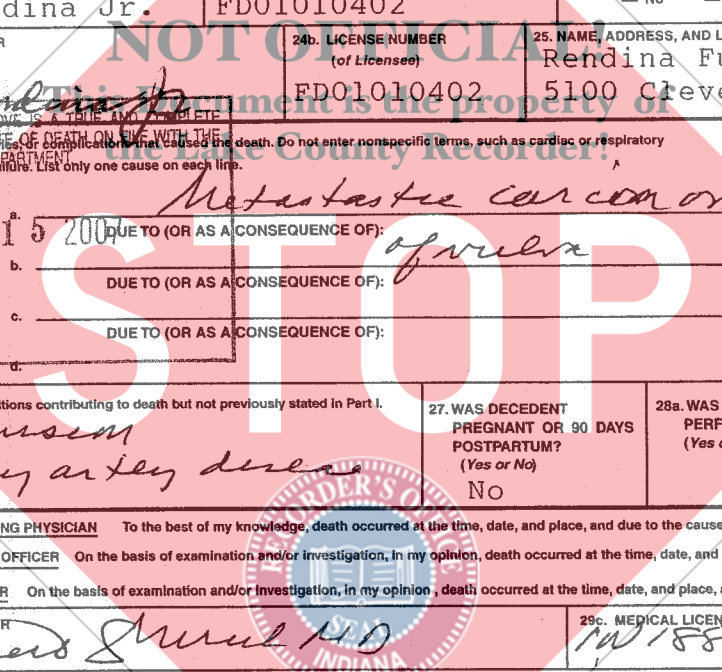
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1. DECEASED-NAME (First, Middle, Last) <b>OLGA MARCHUK</b>				2. SEX <b>Female</b>	3a. TIME OF DEATH <b>1:12p</b>	3b. DATE OF DEATH (Month, Day, Year) <b>March 12, 2007</b>
4. *SOCIAL SECURITY NUMBER <b>309-22-7812</b>		5a. AGE - Last Birthday (Years) <b>80</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>June 3, 1926</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		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) <b>4619 E. 104th</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Crown Point</b>		9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Widowed</b>		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) <b>Housewife</b>		12b. KIND OF BUSINESS/INDUSTRY
13a. RESIDENCE - STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Crown Point</b>		13d. STREET AND NUMBER <b>4619 E.104th</b>
13e. ZIP CODE <b>46307</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>White</b>	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)
18. FATHER'S NAME (First, Middle, Last) <b>Unifer Baranchik</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosie Kauchak</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Gregory Marchuk</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>4619 E. 104th St. Crown Point, In</b>			20c. Relationship <b>Son</b>
21a. METHOD OF DISPOSITION <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) <b>March 15, 2007</b> <b>St. Mary Orthodox Cemetery</b>		21c. LOCATION - City or Town, State <b>Gary, Indiana</b>	
22a. EMBALMER'S NAME: <b>Anthony S. Rendina Jr.</b>			22b. EMBALMER'S LICENSE NO. (of Licensee) <b>FD01010402</b>		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) <b>FD01010402</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Rendina Funeral Home FH83007819</b> <b>5100 Cleveland St. Gary, In 4640</b>	
26. PART I. IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last						
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>over 1 year</b></p>						
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>Hypertension</b> <b>Coronary artery disease</b>						
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) <b>No</b>			28a. WAS AN AUTOPSY PERFORMED? (Yes or No) <b>No</b>		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 <i>Ernest C. Marich M.D.</i>					29c. MEDICAL LICENSE NO. <b>IN 18511</b>	29d. DATE SIGNED (Month, Day, Year) <b>3/14/07</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>ERNEST C. MARICH M.D. 7001 BROADWAY MERRILLVILLE IN 46404</b>						
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. But. D.O.</i>					32. DATE FILED (Month, Day, Year) <b>March 15, 2007</b>	
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) <b>FILED</b>	34d. DESCRIBE HOW INJURY OCCURRED <b>JUN - 5 2007</b>
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or No) <b>PEGGY HOLINGA KATONA</b> <b>LAKE COUNTY AUDITOR</b>			

TICOR TITLE INSURANCE  
Crown Point, Indiana  
927-2836



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