FROM : 7000000803140 FAX NO. :2196611716 Apr. 19 2007 05:16PM P3

M.

* 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.

Local No. 1615-06

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME * (First, Middle, Last): Albert J. Lesniak
2. SEX: Male
3a. TIME OF DEATH: 4:32 AM
3b. DATE OF DEATH (Month, Day, Year): July 1, 2006
4. *SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): February 10, 1923
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Community Hospital
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): Lillian Orzechowicz
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): President
12b. KIND OF BUSINESS/INDUSTRY: Banking
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Highland
13d. STREET AND NUMBER: 3349 Franklin
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): ; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Albert P. Lesniak
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian (unknown)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Lillian Lesniak
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3349 Franklin, Highland, IN 46322
20c. RELATIONSHIP: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 5, 2006 Kolly-Carroll Cremation Services
21c. LOCATION (City or Town, State): Gary, Indiana
22a. EMBALMER'S NAME: Timothy J. Bowler
22b. EMBALMER'S LICENSE NO.: FD20500035
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01005629
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home – 9039 Kleinman Road Highland, IN 46322 FH10306

CAUSE OF DEATH

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. Hypertensive Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Aortic Aneurysm
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.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 2 DAYS POSTPARTUM? (Yes or no)
28. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY RESULTS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

(Check only one)
☑ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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.

29a. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29b. LICENSE NO.: 01047402
29d. DATE SIGNED (Month, Day, Year): 7-05-2

29c. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 911 Franciscan Pkwy, Rensselaer, Indiana 46321

HEALTH OFFICER

30. HEALTH OFFICER'S SIGNATURE: [signature]
THIS CERTIFIES THE ABOVE IS A TRUE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT
30b. DATE FILED (Month, Day, Year): JUL 5 2006

31. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

021498

SDH06-004 State Form 10112 (R4/10-99) Previous Editions Obsolete

"I affirm, under the penalties for perjury, that I have taken reasonable care to redact each social security number in this document, unless required by law." [signature]

$11 SLS CA #1

20070108523