

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 762

Dec 7 2007
Date Issued [Signature]
Hammond Health Commissioner

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) Timothy Andrew Pudlo			2. SEX Male		3a. TIME OF DEATH 10:55 PM		3b. DATE OF DEATH (Month, Day, Yr.) December 1, 2007						
4. SOCIAL SECURITY NUMBER 316-42-4314		5a. AGE-Last Birthday (Years) 63		5b. UNDER 1 YEAR Months: 0 Days: 0		5c. UNDER 1 DAY Hours: 0 Minutes: 0		6. DATE OF BIRTH (Mo, Day, Yr.) June 6, 1944					
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, 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.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			<input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		9b. CITY, TOWN, OR LOCATION OF DEATH Hammond		9c. COUNTY OF DEATH Lake				
9b. FACILITY NAME (If not institution, give street and number) Saint Margaret Mercy Healthcare Center			10. MARITAL STATUS (Specify) Married			11. SURVIVING SPOUSE (If wife, give maiden name) Linda E. Gaddy			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Entrepreneur		12b. KIND OF BUSINESS/INDUSTRY Food Service		
13a. RESIDENCE-STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hammond			13d. STREET AND NUMBER 16 Roselawn						
13a. ZIP CODE 46324		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. AS 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 <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5-) 2			
18. FATHER'S NAME (First, Middle, Last) Walter John Pudlo			19. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Rose Magda			20a. INFORMANT'S NAME (Type/Print) Linda Pudlo			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Roselawn Hammond, Indiana 46324			20c. Relationship Wife	
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) December 6, 2007 Chapel Lawn Memorial Gardens			21c. LOCATION (City or Town, State) Schererville, Indiana							
22a. EMBALMER'S NAME Edgar C. Gleim			22b. EMBALMER'S LICENSE NO. FD01016173			23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) FDO 8600181			25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Chapel Lawn Funeral Home 8178 Cline Avenue Schererville, Indiana 46375 FH19980051							
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. (ARREST) PULMONARY ARREST CORONARY ARTERY DISEASE													
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): a. CORONARY ARTERY DISEASE b. (ARREST) PULMONARY ARREST c. CORONARY ARTERY DISEASE d. (ARREST) PULMONARY ARREST													
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.													
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO			28a. WAS AN AUTOPSY PERFORMED? PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR			28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO ANATOMY OF CAUSE OF DEATH? (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. 01039547A			29d. DATE SIGNED (Month, Day, Year) 12/06/07 (December)				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) 2075 Indianapolis Blvd Whiting IN 46394 - C. Patel M.D.													
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>									32. DATE FILED (Month, Day, Year) December 7, 2007				
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)		34d. DESCRIBE HOW INJURY OCCURRED 025104				
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) 025104							
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.										