**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. 3832-07

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

| 1. DECEASED—NAME (First, Middle, Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Year) |
|---|---|---|---|
| PETER N. VARICHAK | MALE | 12:41 PM | NOVEMBER 23, 2007 |

| 4. *SOCIAL SECURITY NUMBER | 5a. AGE – Last Birthday (Years) | 5b. UNDER 1 YEAR Months Days | 5c. UNDER 1 DAY Hours Minutes | 6. DATE OF BIRTH (Mo, Day, Yr) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 342-16-3282 | 85 | | | OCT. 1, 1922 | CHICAGO, ILLINOIS |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See instructions.) |
|---|---|---|
| YES | N/A | HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☒ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d COUNTY OF DEATH |
|---|---|---|
| ST. MARGARET MERCY SOUTH | DYER | LAKE |

| 10. MARITAL STATUS (Specify) | 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) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| MARRIED | SOPHIE RANICH | ENGINEERING DEPT. | AMOCO OIL COMP. |

| 13a. RESIDENCE — STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| INDIANA | LAKE | SCHERERVILLE | 143 JUNIPER DR. |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| 46375 | ☐ No ☒ Yes | ☒ No ☐ Yes | U.S.A. | ☒ No ☐ Yes | WHITE | Elementary/Secondary (0-12): 12 | College (1-4 or 5+): |

PARENTS

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| N/A | N/A |

INFORMANT

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) | 20c. Relationship |
|---|---|---|
| SOPHIE VARICHAK | 143 JUNIPER DR. SCHERERVILLE, IND. 46375 | WIFE |

DISPOSITION

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | NOVEMBER 26, 2007 OAK HILL CEMETERY | HAMMOND, INDIANA |

| 22a. EMBALMER'S NAME: | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| ELI VUJKO | FD01008300 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Eli Vujko | FD01008300 | LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307 |

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

Conditions, if any, which gave rise to the immediate cause. stating the underlying cause last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| a. | Cardiorespiratory arrest | Minutes |
| b. | DUE TO (OR AS A CONSEQUENCE OF): Hypertensive cardiovascular disease | Years |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions - Conditions contributing to death but not directly related to Part I.

| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or No) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) |
|---|---|---|
| | | |

CERTIFIER

29a. 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.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. MEDICAL LICENSE NO. | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | 01033711A | 11/26/2007 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

WOE South Pl. Merrillville IN. 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.

| 32. DATE FILED (Month, Day, Year) |
|---|
| November 27, 2007 |

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or No) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could Not Be Determined ☐ Homicide | | | | NOV 27 2007 |

| 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. |
|---|---|
| | |

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THIS DEPARTMENT. LAKE COUNTY HEALTH DEPARTMENT

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SDH06-004 State Form 10110 (R5/1-99)