* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 1903-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 85-43-0072-0016

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): SOPHIE BENCIE
2. SEX: Female
3a. TIME OF DEATH: 12:55PM
3b. DATE OF DEATH (Month Day Yr): August 17, 1999
4. SOCIAL SECURITY NUMBER: 316-09-1882
5a. AGE - Last Birthday (Years): 79
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): July 3, 1920
7. BIRTHPLACE (City and State or Foreign Country): Gary, IN
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): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c. CITY TOWN OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Charles Bencie
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS INDUSTRY: Own Home
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 6129 Juniper Ave.
13e. ZIP CODE: 46403
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+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): Szcyepan Blaszczyk
19. MOTHER'S NAME (First, Middle, Maiden Surname): Jozefa Wielgus

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Charles Bencie
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6129 Juniper Ave., Gary, IN 46403
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): August 20, 1999 Calvary Cemetery
21c. LOCATION - City or Town State: Portage, IN
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO: FD01006463
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Michael L. Reek
24b. LICENSE NUMBER (of Licensee): FD08600270
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 83005613 Rees Funeral Home, Olson Chapel 5341 Central Avenue, Portage, IN 46368

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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. Cerebrovascular accident
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

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? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): 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: Nazzal Obaid M.D.
29c. MEDICAL LICENSE NO: 01023841C
29d. DATE SIGNED (Month Day Year): 08-18-99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): NAZZAL OBAID MD, 8895 BROADWAY, MERRILLVILLE, IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alejandro S. Williams, M.D.
32. DATE FILED (Month Day Year): August 18, 1999

33. 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, 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.

FILED
DEC 18 2007
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR
25173

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1