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. 2281-07

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)
DAVID	V.	KOLENDA	MALE	4:56 A.M.	SEPTEMBER 19, 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)
001-42-0070	56			Dec.1, 1950	Claremont, NH

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	8c. PLACE OF DEATH (Check only one. See Instructions)
No	---	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
THE COMMUNITY HOSPITAL	MUNSTER	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	Denise Bousquet	Engineer Manager	A.M. Manufacturing

13a. RESIDENCE — STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	St. John	10733 Manor 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)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46373	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White		2

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Alfred Kolenda	Margaret Sevigne

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
Denise Kolenda	10733 Manor Dr.,St.John,IN 46373	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) _____	September 24, 2007 Regional Cremation	Munster, IN

22a. EMBALMER'S NAME:	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James Betkowski	FD09200077	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James Betkowski	FD09200077	Elmwood Chapel FHD#1990052 11300 W. 97th Ln, St. John, IN 46373

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. Cardio - respiratory arrest	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): bowel perforation	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

FILED
DEC 26 2007
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
P.V. Neelaveni	01056972A	SEPTEMBER 21, 2007

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

PADMAJA NEELAVENI, M.D. 701 SUPERIOR AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Susan W Burt D.O.	September 24, 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				

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)
	SEP 24 2007

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.
	025543

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