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. 3023-07

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, Yr.)
Mary	Czajka	Female	1:11 AM	12/16/07 December 16, 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)
339-03-3940	98			March 26, 1909	Italy

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9e. 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
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
Widowed	None	Homemaker	Own Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Munster	405 Old Stone Road #3

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)	
46321	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	Elementary/Secondary (0-12): 8	College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Peter Pannitto	Elvira Unavailable

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
Vera Newman	405 Old Stone Rd.; Munster, IN 46321	Daughter

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)	December 20, 2007 Holy Cross Cemetery	Calumet City, IL

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

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James F. Betkowski	FD09200077	Elmwood Chapel FHD#19900052 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. INTRACEREBRAL BLEED	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): CARDIOPULMONARY ARREST	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

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	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)
[signature]	01054124A7	12/27/07

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

[illegible], 13 W. US 30, Schererville, IN 46375

HEALTH OFFICER

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

32. DATE FILED (Month, Day, Year): December 18, 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)

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 WITH THE LAKE COUNTY HEALTH DEPARTMENT.

DEC 18 2007

24711

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

Parcel # 18-26-363-037