

* 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

State No.

Local No. 1746-07
932770

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

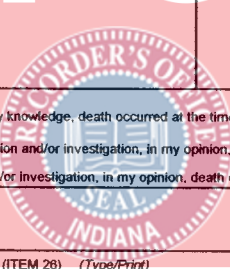
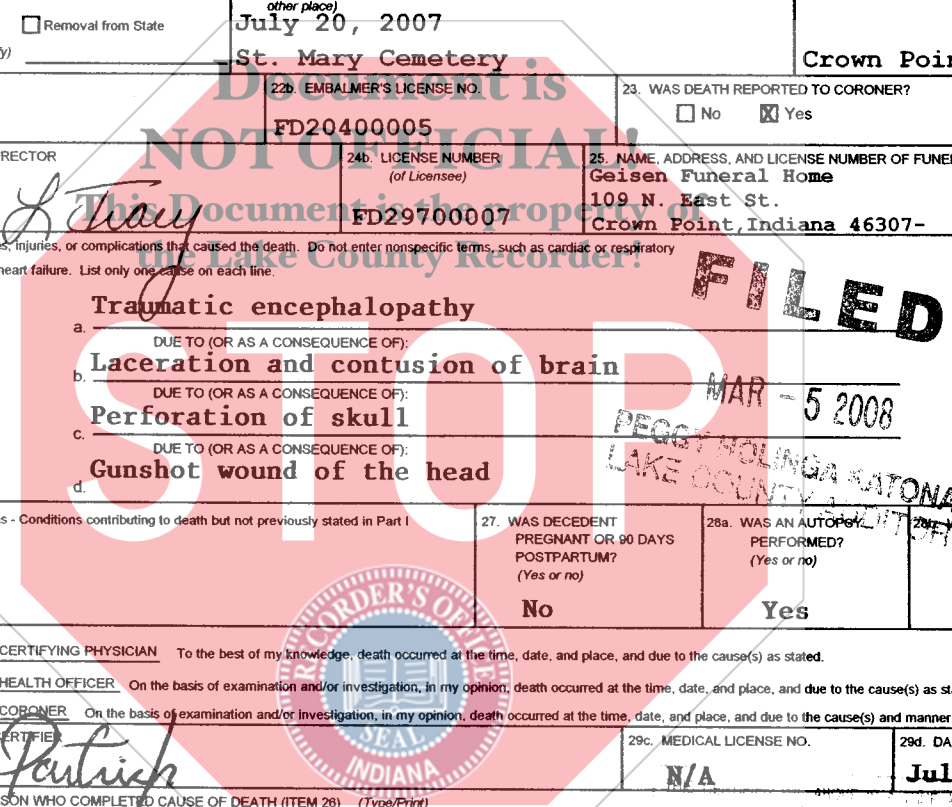
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) Doris Jean Patzsch		2. SEX Female	3a. TIME OF DEATH 7:07 PM	3b. DATE OF DEATH (Month, Day, Yr.) July 16, 2007
4. *SOCIAL SECURITY NUMBER 345-28-1486	5a. AGE - Last Birthday 2007 07 03	5b. UNDER 1 YEAR? Months 0	5c. UNDER 1 DAY Hours 0	5d. UNDER 1 DAY Minutes 0
6. DATE OF BIRTH (Mo., Day, Yr.) July 03, 1935		7. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois		
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	PLACE OF DEATH (Check only one. See instructions)		
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) 869 Clearwater Cove		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) N/A	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 Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Crown Point	13d. STREET AND NUMBER 869 Clearwater Cove	
13e. ZIP CODE 46307-	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16. RACE - American Indian, Black, White, etc. (Specify) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)		17. DECEDENT'S EDUCATION (Specify only highest grade completed)		
Elementary/Secondary (0-12)		College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) John Toth		19. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Gayla		
20a. INFORMANT'S NAME (Type/Print) Cindy Jacobs		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 691 W. 127th Pl. Crown Point, IN 46307-	20c. Relationship Daughter	
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) July 20, 2007 St. Mary Cemetery		21c. LOCATION - City or Town, State Crown Point, Indiana
22a. EMBALMER'S NAME Kevin Knaga		22b. EMBALMER'S LICENSE NO. FD20400005	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Michelle L. Tracy</i>		24b. LICENSE NUMBER (of Licensee) FD29700007	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home 109 N. East St. Crown Point, Indiana 46307- FH19900060	
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. Traumatic encephalopathy DUE TO (OR AS A CONSEQUENCE OF): Laceration and contusion of brain Perforation of skull Gunshot wound of the head				Approximate Interval Between Onset and Death Unknown
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) Yes	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes	
29a. CERTIFIER (Check only one) <input 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 checked="" 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>David J. Pastrick</i>		
29c. MEDICAL LICENSE NO. N/A		29d. DATE SIGNED (Month, Day, Year) July 18, 2007		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) David J. Pastrick, Lake County Coroner, 2900 West 93rd Avenue, Crown Point, IN 46307				
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>				32. DATE FILED (Month, Day, Year) July 19, 2007
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined	34a. DATE OF INJURY (Month, Day, Year) July 16 2007	34b. TIME OF INJURY Unknown	34c. INJURY AT WORK? (Yes or no) No	34d. DESCRIBE HOW INJURY OCCURRED Gunshot wound
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) Residence			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 869 Clearwater Cove Crown Point, Indiana	
34g. DATE PRONOUNCED DEAD (Month, Day, Year) July 16, 2007	34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. No		001877	



PROPERTY TITLE GROUP 7080056PT
Tiger CP