

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 191-041

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANTS

INFORMANT

DISPOSITION

USE OF AUTHORITY

CERTIFIER

ALTH OFFICER

1 DECEASED—NAME (First Middle Last) ALBERT F. BARANOWSKI JR.		2 SEX MALE	3a TIME OF DEATH 9:00 AM	3b DATE OF DEATH (Month Day, Yr) JANUARY 20, 2004
4. *SOCIAL SECURITY NUMBER 316-18-7132		5a AGE—Last Birthday (Years) 81	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6a WAS DECEDENT A US VETERAN? Yes		6b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" 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) THE COMMUNITY HOSPITAL		9c CITY, TOWN OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Mary Gard	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Electrician	
12b KIND OF BUSINESS/INDUSTRY Steel Manufacturing				
13a RESIDENCE—STATE Indiana		13b COUNTY Lake	13c CITY, TOWN OR LOCATION Highland	
13d STREET AND NUMBER 9149 Highland Street				
13e ZIP CODE 46322		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) <input checked="" type="checkbox"/> College (1-4 or 5+) 2				
18 FATHER'S NAME (First, Middle, Last) Albert F. Baranowski Sr.		19 MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Novak		
20a INFORMANT'S NAME (Type/Print) Mary Baranowski		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9149 Highland St. Highland, In. 46322		20c Relationship Wife
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) January 24, 2004 Catholic Cemeteries		21c LOCATION (City or Town, State) Hammond, Indiana
22a EMBALMER'S NAME David R. Peterson		22b EMBALMER'S LICENSE NO. FDO8601585		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>David R. Peterson</i>		24b LICENSE NUMBER (of Licensee) FDO8601585		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, In. 46322 FH10300021
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) a. <i>Respiratory Failure</i> b. <i>Sepsis</i> c. <i>pneumonia</i> d. <i>Diabetes mellitus</i> <i>Congestive Heart Failure</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)		29a CERTIFIER (Check only one) <input checked="" 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 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>L.R. and D.</i>		29c MEDICAL LICENSE NO. 01055296A		29d DATE SIGNED (Month Day, Year) JANUARY 21, 2004
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) XIAO LI, M.D. 7905 CALUMET AVENUE—MUNSTER, INDIANA 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Susan J. Butts, D.O.</i>				32 DATE FILED (Month Day, Year) JANUARY 22, 2004
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day, Year) JUN 4 2008	34b TIME OF INJURY	34c WHETHER AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home, farm, or other place of business, building, etc. (Specify) LAKE COUNTY AUDITOR		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)		34g DATE PRONOUNCED DEAD (Month Day, Year)		
34h MOTOR VEHICLE ACCIDENT? (If yes, specify driver, passenger, pedestrian, etc)		009355		



FILED

JUN 4 2008

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

BURNETT TITLE 16-27-307-38 Ticker 800322 BT