

* 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

Local No. 2554-99

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

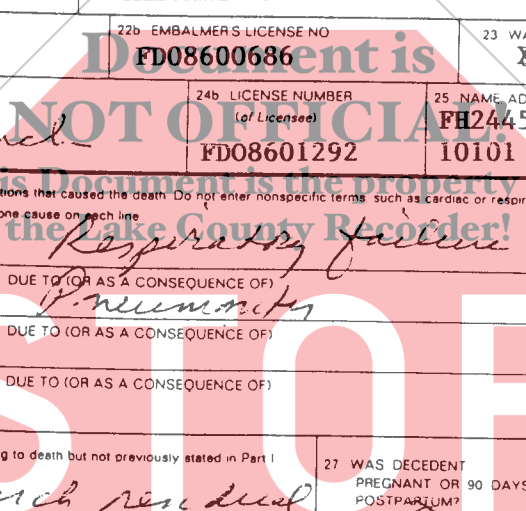
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle, Last) PETE RISTIC		2 SEX MALE	3a TIME OF DEATH 2:30 AM	3b DATE OF DEATH (Month Day, Year) NOVEMBER 8, 1999
4 *SOCIAL SECURITY NUMBER 313-12-6205	5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) MAY 31, 1922
7 BIRTHPLACE (City and State or Foreign Country) CAPARI-YUGOSLAVIA	8a WAS DECEDENT A U.S. VETERAN? YES			
8b YEAR LAST SERVED IN U.S. 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) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) ST. ANTHONY'S MEDICAL CENTER		9c CITY TOWN OR LOCATION OF DEATH CROWN POINT	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS MARRIED	11 SURVIVING SPOUSE (Type/Print) DOROTHY RISTIC	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) PACKER		12b KIND OF BUSINESS INDUSTRY GARY SCREW & BOLT
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION CROWN POINT	13d STREET AND NUMBER 9860 MONROE STREET	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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 College (1-4 or 5+) 12		18 FATHER'S NAME (First Middle, Last) NIKOLA RISTIC		
19 MOTHER'S NAME (First Middle, Maiden Surname) VASILKA		20a INFORMANT'S NAME (Type/Print) DOROTHY RISTIC		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9860 MONROE, CROWN POINT, IN 46307		20c Relationship WIFE		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) NOVEMBER 11, 1999 CALUMET PARK CEMETERY		21c LOCATION—City or Town, State MERRILLVILLE, IN
22a EMBALMER'S NAME DAVID SEMPLINSKI		22b EMBALMER'S LICENSE NO. FD08600686		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Jovan Samich</i>		24b LICENSE NUMBER (of Licensee) FD08601292	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH2445-BURNS FUNERAL HOME, 10101 BROADWAY, CROWN POINT, IN 46307	
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. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF) b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Central infarct resolved				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
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>Ernest C. M. Rich</i>		29c MEDICAL LICENSE NO. 18811	29d DATE SIGNED (Month Day, Year) 11/9/99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ERNEST C. M. RICH 9001 BROADWAY MERRILLVILLE				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander J. Wilkins, MD</i>		32 DATE FILED (Month Day, Year) November 12, 1999		
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) AUG 26 2008	34b TIME OF INJURY FILED	34c INJURY AT WORK? (Yes or no) NO
34d DESCRIBE HOW INJURY OCCURRED \$11 wed TH		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) LAKE COUNTY KATONA		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 013377		34g DATE PRONOUNCED DEAD (Month Day Year)		
34h MOTOR VEHICLE ACCIDENT (Yes or no) If yes, specify driver, passenger, pedestrian, etc. LAKE COUNTY AUDITOR				



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NOV 12 1999
MERRILLVILLE, IN
FILED
CLERK OF COURT
LAKE COUNTY

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