

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. 2177-07

00918 THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

COMMUNITY TITLE COMPANY
FILE NO 240276

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) HELEN J. VAVREK		2 SEX FEMALE	3a TIME OF DEATH 9:12 P M	3b DATE OF DEATH (Month, Day, Yr.) SEPTEMBER 8, 2007	
4 *SOCIAL SECURITY NUMBER 325-20-7629	5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) DECEMBER 22, 1927	
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	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) COMMUNITY HOSPITAL		9c CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) WIDOWED	11 SURVIVING SPOUSE (If wife, give maiden name) NONE	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 HAMMOND		13d STREET AND NUMBER 4030 HENRY AVENUE	
13e ZIP CODE 46327	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) 067 College (1-4 or 5+) 2		18 FATHER'S NAME (First, Middle, Last) STANLEY STRZELEC			
19 MOTHER'S NAME (First, Middle, Maiden Surname) MARY FRUGA		20a INFORMANT'S NAME (Type/Print) KENNETH VAVREK			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 STATELINE, HAMMOND, INDIANA 46324		20c Relationship SON			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) SEPTEMBER 12, 2007 CALUMET PARK MAUSOLEUM		21c LOCATION—City or Town, State MERRILLVILLE, INDIANA	
22a EMBALMER'S NAME KEITH D. ANTHONY		22b EMBALMER'S LICENSE NO. 01011911		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D Anthony</i>		24b LICENSE NUMBER (of licensee) 01011911		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ, FH 33002835 4404 CAMERON, HAMMOND, INDIANA 46327	
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 END Stage Renal Disease DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between One Cause and Death MONTHS YEARS	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b Hypertensive Kidney disease 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.					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? NO		28a WAS AN AUTOPSY PERFORMED? NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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>H. Alan Jones D.O.</i>			29c MEDICAL LICENSE NO. 02000040		
29d DATE SIGNED (Month, Day, Year) SEPTEMBER 10, 2007					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) H.A. JONES D.O., 929 RIDGE ROAD, MUNSTER, INDIANA 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Suzanne W. But D.O.</i>				32 DATE FILED (Month, Day, Year) September 11, 2007	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year) SEP 22 2008	34b TIME OF INJURY FILED	34c DESCRIBE HOW INJURY OCCURRED \$11 WED CM	
34a PLACE OF INJURY—At home, farm, street, factory, building, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		34c 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) <input type="checkbox"/> Yes <input type="checkbox"/> No Driver, passenger, pedestrian, etc. 015789			