



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

928-4933 MD

TICOR TITLE INSURANCE

Local No. 1132-08 K# 45-11-26-154-005.000-050

State No. ....

1. Decedent's Legal Name (First, Middle, Last) <b>BARBARA A. GATES</b>				1a. Maiden Last Name (If Female) <b>STAHOVIAK</b>		2. Sex <b>FEMALE</b>	3. Time Of Death <b>11:50 A.M.</b>	4. Date Of Death (Month/Day/Year) <b>APRIL 1, 2008</b>		
5. Social Security Number <b>311-28-0316</b>	6a. Age - Yrs <b>76</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year) <b>MAY 8, 1931</b>		8. Birthplace (City And State Or Foreign Country) <b>MICHIGAN CITY, INDIANA</b>		
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)					
11. Facility Name (If Not Institution, Give Street And Number) <b>8821 LEE STREET</b>										
12. City Or Town, State, And Zip Code <b>CROWN POINT, INDIANA 46307</b>					13. County Of Death <b>LAKE</b>		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation <b>TEACHER</b>		17. Kind Of Business/Industry <b>EDUCATION</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>			18b. City Or Town <b>CROWN POINT</b>					
18c. Street And Number <b>8821 LEE STREET</b>				18d. Apt. No.		18e. Zip Code <b>46307</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
19. Decedent's Education <b>MASTER'S DEGREE</b>			20. Decedent Of Hispanic Origin <b>NO</b>			21. Decedent's Race <b>WHITE</b>				
22. Father's Name (First, Middle, Last) <b>WILLIAM STAHOVIAK</b>				23. Mother's Name (First, Middle, Last) <b>JULIA STAHOVIAK</b>			23a. Mother's Maiden Last Name <b>ARROWSMITH</b>			
24. Informant's Name <b>KEVIN W. GATES</b>			24a. Relationship To Decedent <b>SON</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>3151 BURGE DRIVE, CROWN POINT, INDIANA 46307</b>					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>SOLAN-PRUZIN CREMATORY</b>			25c. Location - City, Town, And State <b>SCHERERVILLE, INDIANA</b>					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>SOLAN-PRUZIN FUNERAL HOME &amp; CREMATORY 14 KENNEDY AVENUE, SCHERERVILLE, INDIANA 46375</b>			27a. Funeral Home License Number: <b>FH10200037</b>			27b. Signature Of Indiana Funeral Service Licensee: <i>John L. Bruyn</i>		
27c. License Number (Of Licensee) <b>FD01007231</b>		28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. <b>LUNG CANCER</b>								
28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I		29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			38. Location Of Injury - State		38a. City Or Town	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number			38c. Apt. No.		38d. Zip Code <b>016048</b>	
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41. Signature, Of Person Certifying Cause Of Death: <i>P. Drasga</i>						42. Profession (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>RAY DRASGA, M.D. 1205 S. MAIN ST., CROWN POINT, INDIANA 46307</b>						44. License Number <b>#01031484</b>		45. Date Certified <b>APRIL 03, 2008</b>		
46. Additional Funeral Service Provider:						47. *Akas: <b>\$11 (rev)</b>				
48. Signature of Local Health Officer: <i>Susan W. Best, D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>April 4, 2008</b>				

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LAKE COUNTY RECORDS  
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