ATTENTION ESTATE: The Social Security # is eing requested by this state agency in order to ursue its statutory responsibility. Disclosure is oluntary and there will be no penalty for refusal.

ocal No. 3081-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 Parcel # 45-11-26-152-012-000-032

YPE/PRINT IN ERMANENT BLACK INK

ECEDENT

1. DECEASED–NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
RUDY HOJCUS	MALE	2:30 P M	DECEMBER 24, 2007

4. *SOCIAL SECURITY NUMBER	5a. AGE – Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day, Yr)	7. BIRTHPLACE (City and State or foreign Country)
310-22-3682	79			MAY 8, 1928	BURDOCK, PA.

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: [X] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. ANTHONY HOSPITAL	CROWN POINT	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/ INDUSTRY
MARRIED	DORIS DAHLIN	STEEL WORKER	INLAND STEEL COMP.

13a. RESIDENCE — STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	CROWN POINT	8910 LEE ST.

13e. ZIP CODE: 46307

13f. INSIDE CITY LIMITS: [ ] No [X] Yes

13g. ON A FARM? [X] No [ ] Yes

14. CITIZEN OF WHAT COUNTRY? U.S.A.

15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] 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): 12 College (1-4 or 5 +):

ARENTS

18. FATHER'S NAME (First, Middle, Last): ANDI HOJCUS

19. MOTHER'S NAME (First, Middle, Maiden Surname): MAGDA OCEL

NFORMANT

20a. INFORMANT'S NAME (Type/Print): DORIS HOJCUS

20b. MAILING ADDRESS (Street and Number or Rual Route Number, City or Town, State, Zip Code): 8910 LEE ST. CROWN POINT, IN. 46307

20c. Relationship: WIFE

ISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 27, 2007 N.W. IND. CREMATION SERVICE

21c. LOCATION—City or Town, State: CROWN POINT, INDIANA

22a. EMBALMER'S NAME: N/A

22b. EMBALMER'S LICENSE NO.: N/A

23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b. LICENSE NUMBER (of Licensee): FD01008300

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 4630

AUSE OF EATH

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Pulmonary edema	24 hours
Conditions, if any, which gave rise to the immediate cause, starting the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Acute Renal Failure (oliguric)	4 days
	c. DUE TO (OR AS A CONSEQUENCE OF): Acute on Chronic left heart Failure	9 days
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Adrenal Insufficiency, Atrial fibrillation History of West Nile Encephalitis 2004 with residual mental status changes

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No): NO

28a. WAS AN AUTOPSY PERFORMED? (Yes or No): NO

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

ERTIFIER

29a. CERTIFIER (Check only one)
[X] CERTIFYING PHYSICIAN To the best of my knowlrdge. death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] HEALTH OFFICER On the basis of examination and/or investigation, in my openion, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] CORONER On the basis of examination and/or investigation, in my openion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. MEDICAL LICENSE NO.: 01046970A

29d. DATE SIGNED (Month, Day, Year): 12/27/2007

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SPENCER J. Markowitz 430 Cedar Parkway Schererville, IN 46375-1200

EALTH FFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Best D.O.

32. DATE FILED (Month, Day, Year): December 27, 2007

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined

34a. DATE OF INJURY (Month, Day, Year)

34b. TIME OF INJURY

34c. INJURY AT WORK? (Yes or No)

34d. DESCRIBE HOW INJURY OCCURRED

34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)

34f. 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) If yes, specify driver, passenger, pedestrian, etc.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

DEC 27 2007

018444

11.00 CASH PB

FILED NOV 07 2008 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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RECORDER'S OFFICE SEAL INDIANA

SDH06-004 State Form 10110 (R5/1-99)