



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 879-08 Parcel # 45-07-08-355-012-000-023 State No. _____

1. Decedent's Legal Name (First, Middle, Last) FRANK VIDIMOS		1a. Maiden Last Name (If Female)		2. Sex M MALE		3. Time Of Death 1:45 A.M.		4. Date Of Death (Month/Day/Year) MARCH 12, 2008	
5. Social Security Number 318-20-0141		6a. Age Yrs 81		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) May 26, 1926		8. Birthplace (City And State Or Foreign Country) Chicago Heights, IL					
9. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" 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 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) THE COMMUNITY HOSPITAL									
12. City Or Town, State, And Zip Code MUNSTER, INDIANA 46321				13. County Of Death LAKE		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name Barbara Vidimos			15a. (If Wife) Give Maiden Last Name Lorance			16. Decedent's Usual Occupation Sheet Metal Worker		17. Kind Of Business/Industry Steel	
18. Residence - State Indiana			18a. County Lake		18b. City Or Town Hammond				
18c. Street And Number 7353 New Hampshire						18d. Apt. No.	18e. Zip Code 46323	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education 12 +2 Please select education level:			20. Decedent Of Hispanic Origin No Please select Hispanic origin, if any:			21. Decedent's Race White Please select race:			
22. Father's Name (First, Middle, Last) Frank I. Vidimos			23. Mother's Name (First, Middle, Last) Antoinette Vidimos			23a. Mother's Maiden Last Name Yucius			
24. Informant's Name Michael Vidimos			24a. Relationship To Decedent Son		24b. Mailing Address (Street And Number, City, State, Zip Code) 7353 New Hampshire Ave. Hammond, IN 46323				
25. Place Of Disposition Chapel Lawn Cemetery Schererville, Indiana									
25a. Method Of Disposition: <input checked="" type="checkbox"/> Burial <input 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)			25c. Location - City, Town, And State				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana 46322			27a. Funeral Home License Number: FH10300021				
27b. Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>					27c. License Number (Of Licensee) FD08800305				
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. Immediate Cause (Final Disease Or Condition Resulting In Death) A. Congestive Heart Failure Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last B. _____ C. _____ D. _____									
28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I Emphysema									
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 type="checkbox"/> No				
31. Did Tobacco Use Contribute To Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input 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				
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury NOV 19 2008		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
38. Location Of Injury - State			38a. City Or Town PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR			38c. Apt. No.		38d. Zip Code	
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) \$1125			
41. Signature Of Person Certifying Cause Of Death: <i>[Signature]</i>					42. Certifier (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: STUART KLEIN, M.D. 3100 45TH STREET HIGHLAND, INDIANA 46322					44. License Number 01031791A		45. Date Certified MARCH 12 2008		
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <i>[Signature]</i>					49. For Registrar Only - Date Filed (Month/Day/Year): March 13, 2008 018528				