

Key# 45-07-35-405-014.000-006

45-07-35-405-013.000-006

INDIANA STATE DEPARTMENT OF HEALTH

45-07-35-405-012.000-006

CERTIFICATE OF DEATH

State No. ....

45-07-35-405-011.000-006

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

Local No. 0300113

REPRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANT

POSITION

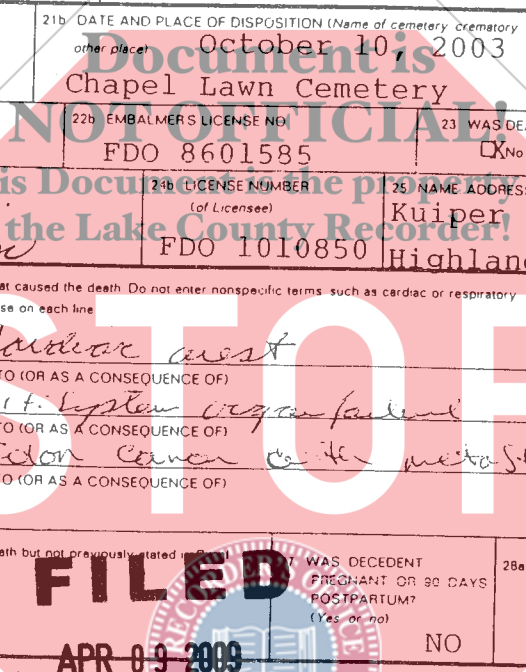
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-2-10

1 DECEASED—NAME (First Middle Last) John Joseph Palınca, Sr.		2 SEX Male	3a TIME OF DEATH 9:20 PM	3b DATE OF DEATH (Month Day Yr) October 6, 2003	
4 *SOCIAL SECURITY NUMBER 311-28-1334	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) Oct. 22, 1932	
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN	8a WAS DECEDENT A US VETERAN? YES	8b YEAR LAST SERVED IN US ARMED FORCES? 1953	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 Franciscan Hospice		9c CITY TOWN OR LOCATION OF DEATH Crown Point	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Virginia Barron	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Sheet Metal Worker	12b KIND OF BUSINESS/INDUSTRY Union		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Griffith	13d STREET AND NUMBER 501 E. Elm St		
13e ZIP CODE 46319	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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 (0-12) College (1-4 or 5 + ) 12		18 FATHER'S NAME (First Middle Last) Joseph Palınca			
19 MOTHER'S NAME (First Middle Maiden Surname) Barbara Unavailable		20a INFORMANT'S NAME (Type/Print) Virginia Palınca			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 E. Elm St. Griffith, IN 46319		20c Relationship Wife			
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) October 10, 2003 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Schererville, IN	
22a EMBALMERS NAME David Peterson		22b EMBALMER'S LICENSE NO. FDO 8601585	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>James S. Scher...</i>		24b LICENSE NUMBER (of Licensee) FDO 1010850	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Highland, IN FH-19900008		
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	Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF)		
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b	Mult. system organ failure DUE TO (OR AS A CONSEQUENCE OF)		
		c	Colon cancer with metastatic disease DUE TO (OR AS A CONSEQUENCE OF)		
		d			
PART II Other significant conditions - Conditions contributing to death but not previously stated					
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) N/A	
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, 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 official capacity, 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>Peggy Holinga Katona</i> LAKE COUNTY AUDITOR			
29c MEDICAL LICENSE NO.		29d DATE SIGNED (Month Day Year) 10-9-03			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. TROY STEVALL 952 S COURIST CROWN POINT, IN					
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>		32 DATE FILED (Month Day Year) October 9, 2003			
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)	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) 11-96			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			



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