10cc

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

Local No. 0446-03

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): LEONORE E. HASZA
2. SEX: Female
3a. TIME OF DEATH: 8:45 AM
3b. DATE OF DEATH (Month, Day, Yr.): October 13, 2003
4. *SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): June 13, 1926
7. BIRTHPLACE (City and State or Foreign Country): Royal Pennsylvania
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 734 Lincoln Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Ben Hasza
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Court Clerk
12b. KIND OF BUSINESS/INDUSTRY: Government
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 734 Lincoln Street
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
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 +):

2003 025717

PARENTS

18. FATHER'S NAME (First, Middle, Last): Michael Stanik
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Lucas

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ben B. Hasza
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 734 Lincoln Street, Hobart, IN 46342
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Oct 17, 2003 Calvary Crematory
21c. LOCATION—City or Town, State: Portage IN
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rees Funeral Home, Inc. FH83003069, 600 W. Old Ridge Road, Hobart, IN 46342-0488

CAUSE OF DEATH

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 ARRHYTHMIA

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): b. ATRIAL FIBRILLATION; DUE TO (OR AS A CONSEQUENCE OF): c. ; DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death: UNKNOWN

FILED APR 16 2009 REGGY OLINGA KATONA LAKE COUNTY AUDITOR

RECORDED AS PRESENTED APR 22 AM 10:57 LAKE COUNTY RECORDER

STATE OF INDIANA LAKE COUNTY I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE AND CORRECT COPY OF THE DOCUMENT AS FILED IN MY OFFICE

COMMUNITY TITLE COMPANY FILE NO 4/1405

PART II. Other significant conditions: Conditions contributing to death but not previously stated in Part I

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): No

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, 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 opinion, 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 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: M.D.
29c. MEDICAL LICENSE NO.: 01047536
29d. DATE SIGNED (Month, Day, Year): 10/15/03

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Andrew Szefler MD 251 W. 84th Drive, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.
32. DATE FILED (Month, Day, Year): 10/16/2003

33. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

$11 CM CM 032858

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