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

Local No. 2733-06

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

Parcel # 45-11-25-277-003.000-036

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

1. DECEASED—NAME (First, Middle, Last): PATRICIA L. POPOVICH		2. SEX: FEMALE	3a. TIME OF DEATH: 10:30 PM	3b. DATE OF DEATH (Month, Day, Yr.): NOVEMBER 11, 2006
4. *SOCIAL SECURITY NUMBER: 304-48-1134	5a. AGE—Last Birthday (Years): 60	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.): JULY 27, 1946
7. BIRTHPLACE (City and State or Foreign Country): PITTSBURGH, 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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence				
9b. FACILITY NAME (If not institution, give street and number): 4971 W. 86th. PL.	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): NIKOLA POPOVICH	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ADMINSTRATIVE ASSISTANT	12b. KIND OF BUSINESS/INDUSTRY: REAL ESTATE MANAGEMENT	
13a. RESIDENCE—STATE: INDIANA	13b. COUNTY: LAKE	13c. CITY, TOWN, OR LOCATION: CROWN POINT	13d. STREET AND NUMBER: 4971 W. 86th. PL.	
13e. ZIP CODE: 46307	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?: ☒ 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 +):				
18. FATHER'S NAME (First, Middle, Last): JOHN BROZANSKI	19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY KLEMENKO			
20a. INFORMANT'S NAME (Type/Print): NIKOLA POPOVICH	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4971 W. 86th. PL. CROWN POINT, IN. 46307	20c. Relationship: HUSBAND		
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): NOVEMBER 15, 2006 ST. MARY'S RUSSIAN ORTH. CEM.	21c. LOCATION—City or Town, State: GARY, INDIANA		
22a. EMBALMER'S NAME: ELI VUJKO	22b. EMBALMER'S LICENSE NO.: FDO1008300	23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR: Eli Vujko	24b. LICENSE NUMBER (of Licensee): FDO1008300	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307		

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. Respiratory syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Alcoholic cirrhosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

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)

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
	01635216	11/14/06

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Alberto R. Sanchez MD 7310 W Lincoln Hwy Crown Point, IN 46307

31. HEALTH OFFICER'S SIGNATURE: Steven J Best D.O.

32. DATE FILED (Month, Day, Year): November 16 2006

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				
	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) 006935	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1