

**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

45-12-13-177-010-000-046

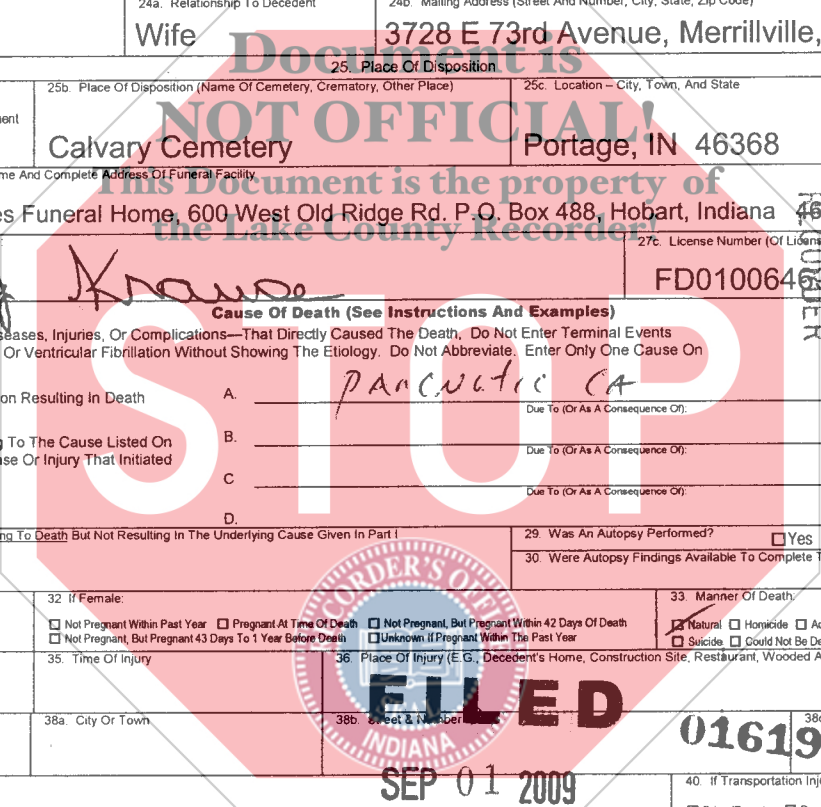
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Local No. 2977-09

State No.

1. Decedent's Legal Name (First, Middle, Last) EDWARD SALAPSKI				1a. Maiden Last Name (If Female) N/A		2. Sex Male	3. Time Of Death 1:00AM	4. Date Of Death (Month/Day/Year) August 19, 2009		
5. Social Security Number 314-24-2124		6a. Age - Yrs 80	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year) April 21, 1929		8. Birthplace (City And State Or Foreign Country) Gary, Indiana	
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 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 checked="" type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)					
11. Facility Name (If Not Institution, Give Street And Number) St. Anthony Nursing Home										
12. City Or Town, State, And Zip Code Crown Point					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 Elizabeth Salapski			15a. (If Wife) Give Maiden Last Name Rearick		16. Decedent's Usual Occupation Industrial Engineer		17. Kind Of Business/Industry Steel			
18. Residence - State IN		18a. County Lake			18b. City Or Town Merrillville		18c. Street And Number 3728 E 73rd Avenue	18d. Apt. No.	18e. Zip Code 464	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education 12+2		20. Decedent Of Hispanic Origin No not Spanish/Hispanic/Latino			21. Decedent's Race White					
22. Father's Name (First, Middle, Last) John Salapski				23. Mother's Name (First, Middle, Last) Bernice Salapski			23a. Mother's Maiden Last Name Buczek			
24. Informant's Name Elizabeth Salapski			24a. Relationship To Decedent Wife		24b. Mailing Address (Street And Number, City, State, Zip Code) 3728 E 73rd Avenue, Merrillville, IN 46410					
25. Place Of Disposition										
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) Calvary Cemetery			25c. Location - City, Town, And State Portage, IN 46368					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Rees Funeral Home, 600 West Old Ridge Rd. P.O. Box 488, Hobart, Indiana 46342						Funeral Home License Number FH83003069		
27b. Signature Of Indiana Funeral Service Licensee <i>James J. Krause</i>						27c. License Number (Of Licensee) FD01006483				
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. pancreatic CA										
Immediate Cause (Final Disease Or Condition Resulting In Death) A. _____ Due To (Or As A Consequence Of): B. _____ Due To (Or As A Consequence Of): C. _____ Due To (Or As A Consequence Of): D. _____										
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										
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I						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 checked="" type="checkbox"/> No		
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" 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		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		38b. Street & Number 016193		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) 1100 CS				
41. Signature Of Person Certifying Cause Of Death <i>Milton Gasparis</i>										
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: Milton Gasparis MD, 1400 S. Lake Park Avenue Suite 301, Hobart, IN 46342										
46. Additional Funeral Service Provider						44. License Number 01037515		45. Date Certified 8-19-2009		
48. Signature of Local Health Officer: <i>Susan J. Best DO</i>						49. For Registrar Only - Date Filed (Month/Day/Year) August 20, 2009				



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 MICHAEL A. BROWN
 RECORDER
 HOBART, INDIANA