

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 808-07

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

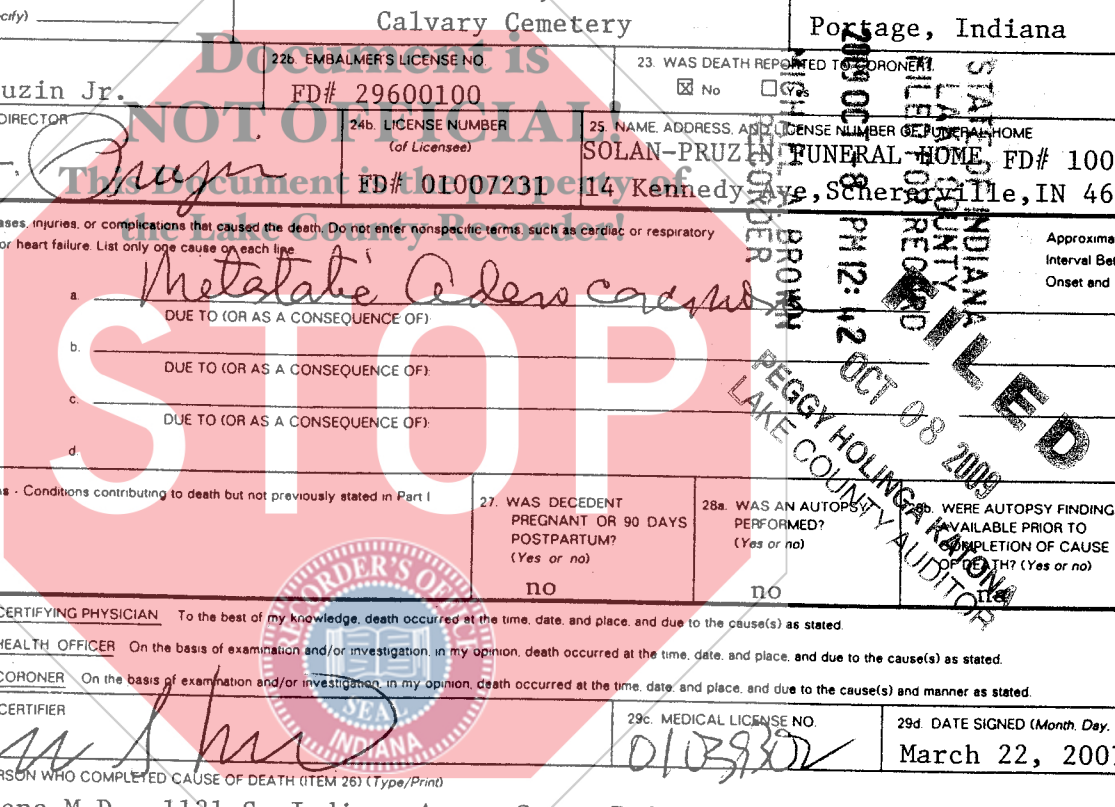
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) NICHOLAS STAMATE				2. SEX Male	3a. TIME OF DEATH 5:10 PM	3b. DATE OF DEATH (Month, Day, Yr.) March 21, 2007
4. *SOCIAL SECURITY NUMBER 309-52-3350	5a. AGE—Last Birthday (Years) 59	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) Feb. 26, 1948	7. BIRTHPLACE (City and State or Foreign Country) Germany	
8a. WAS DECEDENT A U.S. VETERAN? no	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? na	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) St. Anthony 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) Elaine M. Popyk	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker			12b. KIND OF BUSINESS/INDUSTRY Midland Steel Co.	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Cedar Lake		13d. STREET AND NUMBER 10808 W. 132 Place		
13e. ZIP CODE 46303	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
18. FATHER'S NAME (First, Middle, Last) Nicholas Stamate			19. MOTHER'S NAME (First, Middle, Maiden Surname) Renata Schultz			
20a. INFORMANT'S NAME (Type/Print) Elaine M. Stamate			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10808 W.-132 Pl, Cedar Lake, IN 46303		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) March 26, 2007 Calvary Cemetery			21c. LOCATION—City or Town, State Portage, Indiana	
22a. EMBALMER'S NAME John S. Pruzin Jr.		22b. EMBALMER'S LICENSE NO. FD# 29600100		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John S. Pruzin Jr.</i>		24b. LICENSE NUMBER (of Licensee) FD# 0100723P		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN-PRUZIN FUNERAL HOME, FD# 100723 14 Kennedy Ave, Schererville, IN 46375		
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. Metastatic Oesophagus Cancer DUE TO (OR AS A CONSEQUENCE OF) a. _____ b. _____ c. _____ d. _____				Approximate Interval Between Onset and Death		
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		
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, in my opinion, 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 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 <i>Susan W. Best</i>				29c. MEDICAL LICENSE NO. 01039302		
29d. DATE SIGNED (Month, Day, Year) March 22, 2007						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Bernardo Lucena M.D., 1121 S. Indiana Ave., Crown Point, Indiana 46307						
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best</i>						
32. DATE FILED (Month, Day, Year) 28, 2						
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. 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) MAR 28 2007	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				
		017064				



INDIANA
LAKE COUNTY
FILED
OCT 08 2009
PEGGY HOLINGA
LAKE COUNTY AUDITOR

45-15-21-353-007-000-010

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