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. 434

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State # 45-03-07-431-042 000-023

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
July 17, 2007 — Date Issued — Hammond Health Commissioner

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): Phyllis M. Livingston
2. SEX: Female
3a. TIME OF DEATH: 2:26P. M
3b. DATE OF DEATH (Month, Day, Year): July 14, 2007
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE – Last Birthday (Years): 61
5b. UNDER 1 YEAR – Months / Days:
5c. UNDER 1 DAY – Hours / Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): July 5, 1946
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, IN
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Melvin E. Livingston
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Operator
12b. KIND OF BUSINESS/INDUSTRY: Computer
13a. RESIDENCE — STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Whiting
13d. STREET AND NUMBER: 2310 White Oak Avenue
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Frank Banaszak
19. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanore Frankowiak

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Melvin E. Livingston
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code): 2310 White Oak Ave. Whiting, IN 46394
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 19, 2007 Holy Cross Cemetery
21c. LOCATION – City or Town, State: Calumet City, IL
22a. EMBALMER'S NAME: David W. Ruzich
22b. EMBALMER'S LICENSE NO.: FD01008643
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: David W. Ruzich
24b. LICENSE NUMBER (of Licensee): FD01008643
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Ruzich Funeral Home & Cremation Servic, 2031 Indianapolis Blvd., Whiting, IN 46394

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Right Sided Heartfailure
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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)
[X] 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: O. Achufusi, MD
29c. MEDICAL LICENSE NO.: 01061302A
29d. DATE SIGNED (Month, Day, Year): July 17, 07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): O. Achufusi MD 5454 Hohman Ave, Hammond, IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] Peggy Holinga Katona MD
32. DATE FILED (Month, Day, Year): July 17, 2007

FILED DEC 02 2009 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Could not be determined [ ] Suicide [ ] Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or No)
34d. DESCRIBE HOW INJURY OCCURRED: 11 AO
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): 014232 65
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 (R5/1-99)