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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. 2001 000196

Local No. 0114-01

TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

1. DECEDENT—Name (First, Middle, Last): THOMAS W. KOVACEVIC	2. SEX: Male	3a. TIME OF DEATH: 11:05 P.M.	3b. DATE OF DEATH: January 12, 2001	
4. SOCIAL SECURITY NUMBER: [redacted]	5a. AGE—Last Birthday: 80	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH: November 10, 1920
7. BIRTHPLACE: Chicago, Illinois				
8a. WAS DECEDENT A U.S. VETERAN?: Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946	8c. PLACE OF DEATH: HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)		
9a. FACILITY NAME: Methodist Hospital - Southlake Campus	9b. CITY, TOWN, OR LOCATION OF DEATH: Merrillville	9c. COUNTY OF DEATH: Lake		
10. MARITAL STATUS: Married	11. SURVIVING SPOUSE: Lillian P. Dominik	12a. DECEDENT'S USUAL OCCUPATION: Supervisor	12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Merrillville	13d. STREET AND NUMBER: 5461 Pierce Street	
13e. ZIP CODE: 46410	13f. INSIDE CITY LIMITS: [ ] No [X] Yes	13g. ON A FARM?: [X] No [ ] Yes	14. CITIZEN OF WHAT COUNTRY?: U.S.A.	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+):			
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Harpic				
19. FATHER'S NAME (First, Middle, Last): John Kovacevic				
20a. INFORMANT'S NAME (Type/Print): Lillian P. Kovacevic	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5461 Pierce St, Merrillville, IN 46410	20c. Relationship: Wife		
21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 16, 2001 Calumet Park Cemetery	21c. LOCATION—City or Town, State: Merrillville, Indiana		
22a. EMBALMER'S NAME: Henry Flake	22b. EMBALMER'S LICENSE NO.: FD0109406	23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): 1009893	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 4641		

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter terminal events such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac arrest

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory failure, postoperative

DUE TO (OR AS A CONSEQUENCE OF): c. Adult respiratory distress syndrome

DUE TO (OR AS A CONSEQUENCE OF): d. Postop carotid endarterectomy

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

27. WAS DECEDENT PREGNANT OR IN 30 DAYS POSTPARTUM (Yes or No)?	28a. WAS AN AUTOPSY PERFORMED? (Yes or No)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
No	No	

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 [ ] 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) as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dakota Duncan, MD

29c. MEDICAL LICENSE NO.: 01029[illegible] 29d. DATE SIGNED (Month, Day, Year): 1/18/01

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Dr. Sriwan, 8687 Connecticut, Merrillville, IN 46410

31. HEALTH OFFICER'S SIGNATURE: [signature], M.D.

32. DATE FILED (Month, Day, Year): NOV 30 2009

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. PLACE OF INJURY—At home, farm, street, factory, building, etc. (Specify)

34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)

35a. DATE PRONOUNCED DEAD (Month, Day, Year)

35b. MOTOR VEHICLE ACCIDENT (If yes, specify)

I DECLARE UNDER PENALTIES OF PERJURY THAT I HAVE COMPLETED THE DESCRIPTIONS AND FACTS IN THIS CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. TO BE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

FILED
NOV 30 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

DATE FILED: JAN 19 2001

021201

Indiana State Form 10110 (R4/3-93) Death and FD

COMMUNITY TITLE COMPANY
FILE NO X42626

CERTIFIER

DISPOSITION

PARENTS

INFORMANT

DECEDENT

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