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. 1636-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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): JOSEPH J. LEW

2 SEX: MALE

3a TIME OF DEATH: 11:43 AM

3b DATE OF DEATH (Month, Day, Yr): JULY 2, 2007

4 *SOCIAL SECURITY NUMBER: [redacted]

5a AGE—Last Birthday (Years): 79

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo, Day, Yr): MARCH 8,1928

7 BIRTHPLACE (City and State or Foreign Country): CHICAGO, IL

8a WAS DECEDENT A U.S. VETERAN?: YES

8b YEAR LAST SERVED IN US ARMED FORCES?: 1952

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): ST. MARGARET MERCY SOUTH

9c CITY, TOWN, OR LOCATION OF DEATH: DYER

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): MARRIED

11 SURVIVING SPOUSE (If wife, give maiden name): DOLORIS JUREK

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ARMITURE WINDER

12b KIND OF BUSINESS/INDUSTRY: US STEEL

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN, OR LOCATION: DYER

13d STREET AND NUMBER: 740 OSAGE DR.

13e ZIP CODE: 46311

13f INSIDE CITY LIMITS: ☐ No ☒ Yes

13g ON A FARM?: ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: USA

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+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): JOHN LEW

19 MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES DOLEMBA

INFORMANT

20a INFORMANT'S NAME (Type/Print): DOLORIS LEW

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 740 OSAGE DYER,IN.46311

20c Relationship: WIFE

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JULY 6, 2007 HOLY CROSS CEMETERY

21c LOCATION—City or Town, State: CALUMET CITY,IL

22a EMBALMER'S NAME: JAMES F. BETKOWSKI

22b EMBALMER'S LICENSE NO: FD09200077

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FD09200077

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: #FT9900052 Elmwood Funeral Chapel FHD 11300 W.97thLn.St.John,In46373

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. Extensive head injuries	Unknown
	DUE TO (OR AS A CONSEQUENCE OF) b. Due to blunt force trauma	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	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): Yes

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

CERTIFIER

29a CERTIFIER (Check only one): Chief Deputy
☐ 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: [signature]

29c MEDICAL LICENSE NO: N/A

29d DATE SIGNED (Month, Day, Year): July 3, 2007

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Jeffrey R. Wells, Chief Deputy, 2900 West 93rd Avenue, Crown Point, Indiana 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Susan W Burt, D.O.

32 DATE FILED (Month, Day, Year): July 5, 2007

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide

34a DATE OF INJURY (Month, Day, Year): July 2, 2007

34b TIME OF INJURY: Unknown

34c INJURY AT WORK? (Yes or no): No

34d DESCRIBE HOW INJURY OCCURRED: Fall

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): Residence

34f LOCATION (Street and Number or Rural Route Number, City or Town, State): 740 Osage Drive Dyer, Indiana

34g DATE PRONOUNCED DEAD (Month, Day, Year): July 2, 2007

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc: No.

SDH 06-004 State Form 10110 (R5/1-00)

Parcel No. 45-10-13-429-002.000-034

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TICOR TITLE INS.

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FILED MAR 1 8 2010 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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