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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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) NIKOLA MARIC		2. SEX Male	3a. TIME OF DEATH 11:16A_M	3b. DATE OF DEATH (Month, Day, Yr) March 14, 2007
4. *SOCIAL SECURITY NUMBER 313-64-9080	5a. AGE—Last Birthday (Years) 62	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) June 26, 1944
7. BIRTHPLACE (City and State or Foreign Country) Yugoslavia		9a. PLACE OF DEATH (Check only one. See instructions.)		
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence
9b. FACILITY NAME (If not institution, give street and number) Regency Hospital		9c. CITY, TOWN, OR LOCATION OF DEATH Portage	9d. COUNTY OF DEATH Porter	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Radmila Marinkovich	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Industrial Grinder		12b. KIND OF BUSINESS/INDUSTRY Union Tank Company
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Merrillville		13d. STREET AND NUMBER 3319 E. 78th Place
13e. ZIP CODE 46410	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) 12 College (1-4 or 5+) 		18. FATHER'S NAME (First, Middle, Last) Djuro Maric		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Marija Kesic		20a. INFORMANT'S NAME (Type/Print) Radmila Maric		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3319 E. 78th Pl., Merrillville, IN		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 17, 2007 Calumet Park Cemetery		21c. LOCATION—City, Town, State Merrillville, IN
22a. EMBALMER'S NAME David Semplinski		22b. EMBALMER'S LICENSE NO. FD08600686	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Jovan Suvich</i>		24b. LICENSE NUMBER (of Licensee) FD08601292	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH83002445-Burns Funeral Home 10101 Broadway, Merrillville, IN	
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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF)		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. sepsis DUE TO (OR AS A CONSEQUENCE OF)		
		c. infection DUE TO (OR AS A CONSEQUENCE OF)		
		d. cerebro vasculer accident DUE TO (OR AS A CONSEQUENCE OF)		
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>[Signature]</i>			29c. MEDICAL LICENSE NO. 01061624A	29d. DATE SIGNED (Month, Day, Year) 3/20/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jose Agosti 2640 Hamstrom Rd. Portage IN 46368				
31. HEALTH OFFICER'S SIGNATURE <i>Ray A. Bebrock md</i>				32. DATE FILED (Month, Day, Year) March 21, 2007
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) 03 18 2010	34b. TIME OF INJURY FILED	34c. INJURY AT WORK? (Yes) FILED
		34d. DESCRIBE HOW INJURY OCCURRED \$91 CS OA		
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc (Specify) 001 18 2010		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 055483		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE INVOLVED? (Check appropriate box) Passenger, pedestrian, etc. PEGGY HOLINGA KATON LAKE COUNTY AUDITOR		