

10

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No. 3519-10 Resubmit

State No.

1 Decedent's Legal Name (First, Middle, Last) Michael E. Croak				1a Maiden Last Name (If Female)		2 Sex Male		3 Time Of Death 11:25 AM		4 Date Of Death (Month/Day/Year) October 4, 2010	
5 Social Security Number 325-34-9803		6a Age - Yrs 69		6b Under 1 Year Months		6c Under 1 Month Days		6d Under 1 Day Hours		6e Under 1 Hour Minutes	
7 Date Of Birth (Month/Day/Year) August 26, 1941		8 Birthplace (City And State Or Foreign Country) Hammond, Indiana									
9 Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10 If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival				10a If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)					
11 Facility Name (If Not Institution, Give Street And Number) 1543 Gleneagles Dr.											
12 City Or Town, State, And Zip Code Dyer, Indiana 46311						13 County Of Death Lake			14 Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15 Surviving Spouse's Name Beverly Croak				15a (If Wife) Give Maiden Last Name Stretch		16 Decedent's Usual Occupation Quality assurance manager			17. Kind Of Business/Industry Chemical		
18 Residence - State Indiana			18a County Lake			18b City Or Town Dyer					
18c Street And Number 1543 Gleneagles Dr.						18d Apt. No.		18e Zip Code 46311		18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19 Decedent's Education 12			20 Decedent Of Hispanic Origin No			21 Decedent's Race White					
22 Father's Name (First, Middle, Last) Arthur Croak				23 Mother's Name (First, Middle, Last) Dorothy Croak				23a Father's Maiden Last Name Helm			
24 Informant's Name Beverly Croak			24a Relationship To Decedent Wife			24b Mailing Address (Street And Number, City, State, Zip Code) 1543 Gleneagles Dr. Dyer, IN 46311					
25. Place Of Disposition											
25a Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)			25b Place Of Disposition (Name Of Cemetery, Crematory, Other Place) Beverly Cemetery				25c Location - City, Town, And State Blue Island, Illinois				
26 Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Anthony & Dziadowicz Funeral Home 9445 Calumet Ave. Munster, IN 46321						27a Funeral Home License Number FH83002916			
27b Signature Of Indiana Funeral Service Licensee. <i>[Signature]</i>						27c License Number (Of Licensee) FD20800089					
28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.											
Immediate Cause (Final Disease Or Condition Resulting In Death) A. Respiratory Failure Due To (Or As A Consequence Of)											
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last B. Endstage COPD Due To (Or As A Consequence Of)											
C. _____ Due To (Or As A Consequence Of)											
D. _____ Due To (Or As A Consequence Of)											
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I						29 Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31 Did Tobacco Use Contribute To Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown			32 If Female <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33 Manner Of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34. Date Of Injury (Month/Day/Year)			35 Time Of Injury			36 Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			38. Zip Code		
38 Location Of Injury - State			38a City Or Town			38b Street & Number			38c Apt. No.		
39 Describe How Injury Occurred						40 If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)					
41 Signature, Of Person Certifying Cause Of Death <i>[Signature]</i>						42 Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer					
43 Name, Address And Zip Code Of Person Certifying Cause Of Death Mary Tilak, MD 2241 45th Highland, IN 46322						44 License Number 056291			45. Date Certified October 13, 2010		
46 Additional Funeral Service Provider Schroeder-Lauer Funeral Home						47 *Akas					
48 Signature of Local Health Officer <i>[Signature]</i>						49 For Registrar Only - Date Filed (Month/Day/Year) October 14, 2010					

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PEGGY HULINGA KATONA
LAKE COUNTY AUDITOR

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