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. 65-3-04

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 45-09-18-353-047-000-021

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Helen Kasperek
2 SEX: Female
3a TIME OF DEATH: 5:45P M
3b DATE OF DEATH (Month Day Yr): February 24, 2004
4 SOCIAL SECURITY NUMBER: 310-14-3222
5a AGE—Last Birthday (Years): 80
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): August 28, 1923
7 BIRTHPLACE (City and State or Foreign Country): Chicago, IL
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): 2736 Dekalb
9c CITY, TOWN, OR LOCATION OF DEATH: Lake Station
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Theodore
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homaker
12b KIND OF BUSINESS/INDUSTRY: Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Lake Station
13d STREET AND NUMBER: 2736 Dekalb Street
13e ZIP CODE: 46405
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): 8; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Vincent Zowal
19 MOTHER'S NAME (First Middle Maiden Surname): Hedwig Bebnak

INFORMANT

20a INFORMANT'S NAME (Type/Print): Ronald Kasperek
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2736 Dekalb St. Laek Station, IN
20c Relationship: Son

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 28th, 2004 Calvary Cemetery
21c LOCATION—City or Town, State: Portage, Indiana
22a EMBALMER'S NAME: Christopehr Podgorski
22b EMBALMER'S LICENSE NO: FD29300030
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD29300030
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Christopher Funeral Home FH19500025 1307 Central Ave Lake Station, IN 46405

2004-07-200

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. Parkinsons Disease
DUE TO (OR AS A CONSEQUENCE OF) b. Senile Dementia
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): NO
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

2010 DEC 17 ... FILED ... RECORDED

CERTIFIER

29a CERTIFIER (Check only one): ☒ 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: 01033453
29d DATE SIGNED (Month Day Year): 3/10/04
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Carter 295 S. Wisconsin Hobart, IN 46342 219-942-1145

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): March 10, 2004

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month Day Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED
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)
34g DATE PRONOUNCED DEAD (Month Day Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED DEC 17 2010 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR 056699

CS 11.00

SDH06-004 State Form 10110 (R5/1-99)