

45-06-24-127-027.000-027
INDIANA STATE DEPARTMENT OF HEALTH

* 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. 1999-01

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

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) ERWIN PIECZYNSKI				2. SEX MALE		3a. TIME OF DEATH 9:00 A M		3b. DATE OF DEATH (Month, Day, Yr.) SEPTEMBER 7, 2001	
4. *SOCIAL SECURITY NUMBER 357-28-4949		5a. AGE—Last Birthday (Years) 63	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) May 7, 1938		7. BIRTH PLACE (City and State or Foreign Country) CHICAGO, IL.		
8a. WAS DECEDENT A U.S. VETERAN? YES		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1959		9a. PLACE OF DEATH (Check only one See instructions) 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) THE COMMUNITY HOSPITAL				9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER			9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) MARY RUSSELL		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) ELECTRICIAN			12b. KIND OF BUSINESS/INDUSTRY CITY OF CHICAGO		
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION MUNSTER			13d. STREET AND NUMBER 8227 HOHMAN		
13e. ZIP CODE 46321	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) 12 Elementary/Secondary (0-12) College (1-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last) EDWARD PIECZYNSKI				19. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA W. PIECZYNSKI					
20a. INFORMANT'S NAME (Type/Print) Mary Pieczynski				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8227 Hohman Munster, IN 46327				20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) September 10, 2001 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Betkowski</i>			24b. LICENSE NUMBER (of Licensee) FD09200077		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Elmwood Chapel FHD#19900052 11300 W. 97th LN. St. John, 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. <i>intracerebral bleeding</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>acute respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last									
PART II. Other significant conditions - Conditions contributing to death but not previously stated DEC 20 2010 EGGY HOLINGA-KATONA LAKE COUNTY AUDITOR									
27. THIS CERTIFICATE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT									
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>W. Ahdab</i>						29c. MEDICAL LICENSE NO. 01046859		29d. DATE SIGNED (Month, Day, Year) SEPTEMBER 10, 2001	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) WADDAH AHDAB, M.D., 7400 COLUMBIA AVENUE, HAMMOND, INDIANA 46324									
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Betkowski, D.O.</i>								32. DATE FILED (Month, Day, Year) <i>September 10, 2001</i>	
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)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED 005492				
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. 11:00 AM						