

45-16-06-251-000-042

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No. 1965-08

State No.

1 Decedent's Legal Name (First, Middle, Last) FLOYD E. BEDNAR				1a Maiden Last Name (if Female) N/A		2 Sex MALE		3 Time Of Death 3:15PM		4 Date Of Death (Month/Day/Year) MAY 30, 2008				
5 Social Security Number 327-24-8036		6a Age - Yrs 77		6b Under 1 Year Months: _____ Days: _____		6c Under 1 Month Days: _____ Hours: _____ Minutes: _____		6d Under 1 Day Hours: _____ Minutes: _____		7 Date Of Birth (Month/Day/Year) JULY 1, 1932				
8 Birthplace (City And State Or Foreign Country) ILLINOIS		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 checked="" 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) 1070 A EASY ST.														
12 City Or Town, State And Zip Code CROWN POINT						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 DELORES BEDNAR				15a (if Wife) Give Maiden Last Name CHUMRYNSKY		16 Decedent's Usual Occupation DRIVER			17 Kind Of Business/Industry MARSHAL FIELD & CO.					
18 Residence - State INDIANA			18a County LAKE			18b City Or Town CROWN POINT			18c Apt No		18e Zip Code 46307			
18c Street And Number 1070A EASY ST.			18d Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			19 Decedent's Education 12 YRS.			20 Decedent Of Hispanic Origin NO			21 Decedent's Race WHITE		
22 Father's Name (First, Middle, Last) WILLIAM BEDNAR						23 Mother's Name (First, Middle, Last) ELIZABETH			23a Mother's Maiden Last Name WILLER					
24 Informant's Name WILLIAM BEDNAR			24a Relationship To Decedent SON			24b Mailing Address (Street And Number, City, State, Zip Code) 13827 81ST. AVE. DYER, IND. 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 type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)			25b Place Of Disposition (Name Of Cemetery, Crematory, Other Place) MEMORY LANE MEMORIAL GARDENS JUNE 3, 2008			25c Location - City, Town, And State CROWN POINT, INDIANA								
26 Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27 Name And Complete Address Of Funeral Facility LINCOLN RIDGE FUNERAL HOME 7607 W. LINCOLN HWY. CROWN POINT, IND. 46307						27a Funeral Home License Number 88800070		27b Signature Of Indiana Funeral Service Licensee <i>Eli [Signature]</i>		27c License Number (Of Licensee) FDO1008300		
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. Myocardial Infarction			B. Bilateral Cardiomyopathy			C. _____		
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						D. _____			Approximate Interval: Onset To Death DEC 21 2010			FILED PEGGY HULINGA KATONA LAKE COUNTY AUDITOR		
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 type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" 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								
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)			37 Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
38 Location Of Injury - State			38a City Or Town			38b Street & Number			38c Apt. No		38d Zip Code			
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>William G. Cataldi</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 William G. Cataldi, D.O. 840 Richard Rd Dyer, In. 46311						44 License Number 02000476		45 Date Certified 6/3/08						
46 Additional Funeral Service Provider						47 Akas 056748		48 Signature Of Local Health Officer <i>Susan J. Best, D.O.</i>						
						49 For Registrar Only - Date Filed (Month/Day/Year) June 3, 2008								