INDIANA STATE DEPARTMENT OF H' .TH
CERTIFICATE OF DEATH

Local No. 1991-10 Parcel # 45-10-12-178-029.000-034 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
CAROL A. HECIMOVICH	FINKE	F	6:10 P.M.	JUNE 25, 2010

5. Social Security Number	6a. Age Yrs	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)	8. Birthplace (City And State Or Foreign Country)
345-20-0787	81					JANUARY 24, 1929	CHICAGO, IL.

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☒ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): COMMUNITY HOSPITAL

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
MUNSTER, INDIANA, 46321	LAKE	☐ Married ☐ Married But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
NONE		SALESPERSON	RETAIL STORE

18. Residence – State	18a. County	18b. City Or Town
INDIANA	LAKE	DYER

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
1612 ROKOSZ		46311	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
High school graduate or GED completed	No, not Spanish/Hispanic/Latino	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
ADOLPH FINKE	MARTHA	KASPRZYK

24. Informant's Name	24b. Relationship To Decedent	24c. Mailing Address (Street And Number, City, State, Zip Code)
MARK HECIMOVICH	SON	611 ESCANABA; CALUMET CITY, IL. 60409

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☐ Donation ☐ Entombment ☐ Removal From State ☒ Burial ☐ Cremation ☐ Other (Specify):	HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Director License Number
☐ Yes ☒ No	ELMWOOD CHAPEL 11300 W. 97TH LANE ST. JOHN, INDIANA 46373	1899000[illegible]

27b. Signature Of Indiana Funeral Service Licensee: [signature]

27c. License Number (Or Other): FD09200077

FILED DEC 28 2010 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

Cause Of Death (See Instructions And Examples)

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. Idiopathic Pulmonary Fibrosis — 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. — Due To (Or As A Consequence Of)
C. — Due To (Or As A Consequence Of)
D.

Approximate Interval: Onset To Death

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? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death:
☐ Yes ☐ Probably ☐ No ☒ Unknown	☒ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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?
			☐ Yes ☐ No

38. Location Of Injury – State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE [illegible] COUNTY HEALTH DEPARTMENT JUN 28 2010

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature Of Person Certifying Cause Of Death: [signature]

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
KATHRYN MULLIGAN, M.D. 919 MAIN ST. DYER, INDIANA 46311	01052342A	JUNE 28, 2010

46. Additional Funeral Service Provider:	47. "AKAs":

48. Signature Of Local Health Officer:	49. For Registrar Only – Date Filed (Month/Day/Year):
Susan M. Bart D.O.	June 28, 2010 031037

State Form 10110 (R7/9-07) ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to perform its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal. THE RECORDS IN THIS AREA ARE CONFIDENTIAL PER IC 16-37-1-10