

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-03-07-178-013-000-023



Local No 000037

EDR No 00000181811

State No

1. Decedent's Legal Name (First, Middle, Last) JAMES PAUL BAYUS				1a. Maiden Name (If female)		2. Sex MALE	3. Time Of Death 03:05 AM	4. Date Of Death (Month/Day/Year) 02/07/2011	
5. Social Security Number 307-44-8024	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) 06/10/1941		8. Birthplace (City and State or Foreign Country) CHICAGO, IL	
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" 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 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) REGENCY HOSPITAL OF NORTHWEST INDIANA, LLC									
12. City Or Town, State, And Zip Code EAST CHICAGO, IN, 46312					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 LINDA E BAYUS			15a. (If Wife) Give Maiden Last Name ROE			16. Decedent's Usual Occupation OPERATOR		17. Kind Of Business/Industry REFINERY	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town SCHERERVILLE		18d. Apt. No.	18e. Zip Code 46370	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED		20. Decedent Of Hispanic Origin NOT HISPANIC			21. Decedent's Race White				
22. Father's Name (First, Middle, Last) PAUL BAYUS				23. Mother's Name (First, Middle, Last) MARY BAYUS			23a. Mother's Maiden Last Name KAPLAN		
24. Informant's Name LINDA E BAYUS		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 2046 CASTLEVIEW DRIVE, SCHERERVILLE, IN 46375					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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) HEIGHTS CREMATORY			25c. Location - City, Town, And State CHICAGO HEIGHTS, IL				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility OWENS-RUZICH FUNERAL HOME AND CREMATION SERVICE, 816-119TH STREET, WHITING, IN 46394					27a. Funeral Home License Number: FH10700040		
27b. Signature Of Indiana Funeral Service Licensee: JAMES F SEEBERG, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee): FD20900076			
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. Cause Of Death (See Instructions And Examples) Immediate Cause (Final Disease Or Condition Resulting In Death) A. CHF 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. MYASTHENIA GRAVIS Due to (Or As A Consequence Of): C. ARF Due to (Or As A Consequence Of): D. RESPIRATORY INSUFFICIENCY									
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I ASPIRATION, PRESSURE SORES, HYPOTENSION, ARRHYTHMIAS						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" 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 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: LUIS ERNESTO MANYARI, BY ELECTRONIC SIGNATURE						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: LUIS ERNESTO MANYARI, 5529 HOHMAN AVE, HAMMOND, IN 46320						44. License Number 01057087A		45. Date Certified 02/17/2011	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: PAULA BENCHIK-ABRINKO, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): FEB 22 2011			

AMENDMENT TO CERTIFICATE OF DEATH (COPY OR ORIGINAL)