



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

COMMUNITY TITLE COMPANY
FILE NO L111012

Local No. 292-10

State No.

1 Decedent's Legal Name (First, Middle, Last) ALBERT G. LUKOSHUS				1a Maiden Last Name (If Female)		2 Sex Male	3 Time Of Death 07:52 PM	4 Date Of Death (Month/Day/Year) January 26, 2010		
5 Social Security Number 315-16-7564	6a Age - Yrs 85	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) March 31, 1924		8 Birthplace (City And State Or Foreign Country) STREATOR, 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 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) 423 FISHER STREET										
12 City Or Town, State, And Zip Code MUNSTER, INDIANA 46321				13 County Of Death LAKE		14 Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name N/A			15a (If Wife) Give Maiden Last Name		16 Decedent's Usual Occupation FOREMAN		17. Kind Of Business/Industry UNION CARBIDE CO.			
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town MUNSTER		18c. Street And Number 423 FISHER STREET		18d. Apt No B	18e. Zip Code 46321	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education Associate degree (e.g. AA, AS)		20 Decedent Of Hispanic Origin No, not Spanish/Hispanic or Latino		21 Decedent's Race White		22 Father's Name (First, Middle, Last) ALBERT LUKOSHUS, SR.		23 Mother's Name (First, Middle, Last) LUCILLE LUKOSHUS		23a. Mother's Maiden Last Name LUCAS
24. Informant's Name WES LUKOSHUS			24a Relationship To Decedent SON		24b Mailing Address (Street And Number, City, State, Zip Code) 8835 NORTHCOTE, MUNSTER, IN 46321		<div style="display: flex; flex-direction: column; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">2011028931</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">MAY 25 AM 10:37</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">FILED FOR RECORD</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">MUNSTER, INDIANA</div> </div>			
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	27 Name And Complete Address Of Funeral Facility Bocken Funeral Home, Inc. 7042 Kennedy Avenue, Hammond, IN 46323				27a Funeral Home License Number FE10600033		27b. License Number (Of Licensee) FDO8601373			
27c. Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>										
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. CONGESTIVE HEART FAILURE Due To (Or As A Consequence Of) B. _____ Due To (Or As A Consequence Of) C. _____ Due To (Or As A Consequence Of) D. _____ 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										
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 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>[Signature]</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: A. GANDHI, M.D. 10010 DON POWERS DRIVE, MUNSTER, IN 46321-						44 License Number 01029887		45. Date Certified 1/29/10		
46 Additional Funeral Service Provider 052963						47 *Akas				
48. Signature of Local Health Officer <i>[Signature]</i>						PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR Only - Date Filed (Month/Day/Year) January 29, 2010				