INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-16-04-132-007.000-042

Local No 000817 EDR No 000000187900 State No 011289

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
JOHN N CRNJAK		MALE	09:33 AM	03/09/2011

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)
355-12-8549	86					01/27/1925	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)
ST ANTHONY MEDICAL CENTER OF CROWN POINT

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
CROWN POINT, IN, 46307	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
IRENE CRNJAK	RASCHKE	SELF EMPLOYEED	SCRAP YARD

18. Residence - State	18a. County	18b. City Or Town
INDIANA	LAKE	CROWN POINT

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
1160 VILLAGE COURT		46307	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
8TH GRADE OR LESS	NOT HISPANIC	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
JOHN CRNJAK	MARY CRNJAK	FURLON

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
IRENE CRNJAK	WIFE	1160 VILLAGE COURT, CROWN POINT, IN 46307

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	REGIONAL CREMATION	MUNSTER, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	ELMWOOD CHAPEL LTD, 11300 W 97TH LN, SAINT JOHN, IN 46373	FH19900052

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
JAMES F BETKOWSKI , BY ELECTRONIC SIGNATURE	FD09200077

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 Additinal Lines If Necessary.

Approximate Interval: Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death) A. CARDIOVASCULAR COLLAPSE

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. ATRIAL FIBRILLATION

Due to (Or As A Consequence Of):

C. HYPERTENSIVE HEART DISEASE

Due to (Or As A Consequence Of)

D.

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Givin In Part I

RENAL INSUFFICIENCY

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Finding 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

39. Describe How Injury Occurred

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

41. Signature, Of Person Certifying Cause Of Death:
RAKESH KANSAL , BY ELECTRONIC SIGNATURE

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

43. Name, Address And Zip Code Of Person Certifying Cause Of Death	44. License Number	45. Date Certified
RAKESH KANSAL , 297 WEST FRANCISCAN LANE #202, CROWN POINT, IN 46307	01038984A	03/15/2011

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer:
SUSAN W. BEST, VIA ELECTRONIC SIGNATURE

49. For Registrar Only - Date Filed (Month/Day/Year):
MAR 15 2011

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

11 AO CS

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.