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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave Suite 104
Valparaiso IN 46383

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED - NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Peggy	Joyce	Grecco	Female	1:30 pm	November 18, 2005

4. *SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
309-22-7781	79			February 20, 1926	Elwood Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	PLACE OF DEATH (Check only one See instructions)
No	—	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence

DECEDENT

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Valparaiso Care & Rehab.	Valparaiso	Porter

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY
Widowed	N/A	Homemaker	At Home

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Porter	Valparaisio	606 Wall Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE — American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46383	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	10	N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph James	Mamie Shaw

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Roxanne M. Baimakovich	4740 Liverpool Road, Lake Station, IN	Daughter

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
☐ Burial ☒ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	November 21, 2005 NW Indiana Cremation Service	Crown Point, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James F. Burns	01009461	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James F. Burns	FD01009461	Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-

CAUSE OF DEATH

26. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Congestive Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF):	b. Chronic Respiratory Failure	
DUE TO (OR AS A CONSEQUENCE OF):	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Bradycardia	No	No	

CERTIFIER

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	01039826	11/21/05

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	
Douglas Mazurek M.D.	1101 E. Glendale Blvd., Valparaiso, IN 46383

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Mary A. Bobroske MD	November 21, 2005

FILED

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

34e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.
November 18, 2005	

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