INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-08-25-108-013.000-018

Local No 003647 | EDR No 000000230859 | State No 051925

1. Decedent's Legal Name (First, Middle, Last): VICTORIA M KOCHEK
1a. Maiden Name (If female): HALMAGY
2. Sex: FEMALE
3. Time Of Death: 07:20 PM
4. Date Of Death (Month/Day/Year): 11/24/2011
5. Social Security Number: 309-14-5821
6a. Age - Yrs: 91
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): 10/21/1920
8. Birthplace (City and State or Foreign Country): DONALDSON, IN
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 MARY MEDICAL CENTER INC
12. City Or Town, State, And Zip Code: HOBART, IN, 46342
13. County Of Death: LAKE
14. Marital Status At Time Of Death: ☐ 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: CUSTOMER SERVICE
17. Kind Of Business/Industry: DRY CLEANING
18. Residence - State: INDIANA
18a. County: LAKE
18b. City Or Town: HOBART
18c. Street And Number: 2900 WEST 39TH AVENUE
18d. Apt. No.:
18e. Zip Code: 46342
18f. Inside City Limits? ☒ Yes ☐ No
19. Decedent's Education: 9TH - 12TH GRADE; NO DIPLOMA
20. Decedent Of Hispanic Origin: NOT HISPANIC
21. Decedent's Race: White
22. Father's Name (First, Middle, Last): GEORGE HALMAGY
23. Mother's Name (First, Middle, Last): MARIE HALMAGY
23a. Mother's Maiden Last Name: UNAVAILABLE
24. Informant's Name: ROBERT KOCHEK
24a. Relationship To Decedent: SON
24b. Mailing Address (Street And Number, City, State, Zip Code): 2900 WEST 39TH AVENUE, HOBART, IN 46342

25. Place Of Disposition
25a. Method Of Disposition: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):
25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place): CALUMET PARK CEMETERY
25c. Location - City, Town, And State: MERRILLVILLE, IN
26. Was Coroner Contacted? ☐ Yes ☒ No
27. Name And Complete Address Of Funeral Facility: REES FUNERAL HOME, HOBART CHAPEL, 600 W OLD RIDGE RD, HOBART, IN 46342
27a. Funeral Home License Number: FH83003069
27b. Signature Of Indiana Funeral Service Licensee: JAMES J. KRAUSE , BY ELECTRONIC SIGNATURE
27c. License Number (Of Licensee): FD01006463

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.

Approximate Interval: Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death) A. CONGESTIVE HEART FAILURE SECONDARY TO SEVERE AORTIC STENOSIS
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.

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Givin In Part I
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? ☐ Yes ☐ Probably ☐ No ☒ Unknown
32. If Female: ☐ 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
33. Manner Of Death: ☒ 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: MILTON STANLEY GASPARIS , 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: MILTON STANLEY GASPARIS , 1400 SOUTH LAKE PARK AVE, STE. 301, HOBART, IN 46342
44. License Number: 01037515A
45. Date Certified: 11/29/2011
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): NOV 29 2011

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AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

029731

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.

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP

FILED DEC 07 2011 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

2011 070536 FILED FOR RECORD 2011 DEC -7 AM 11:09 MICHAEL B. BROWN RECORDER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

COPY OF THE CERTIFICATE ... ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT NOV 30 2011