COMMUNITY TITLE COMPANY
FILE NO L111884

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

Local No. 1981-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ANN TKACH
2. SEX: FEMALE
3a. TIME OF DEATH: 6:00A M
3b. DATE OF DEATH (Month, Day, Yr.): AUGUST 9, 2007
4. *SOCIAL SECURITY NUMBER: 309-14-9426
5a. AGE—Last Birthday (Years): 88
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): JULY 26, 1919
7. BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XX ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): 1206 EUCLID AVENUE
9c. CITY, TOWN, OR LOCATION OF DEATH: WHITING
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): WIDOWED
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY: OWN HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: WHITING
13d. STREET AND NUMBER: 1206 EUCLID AVENUE
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS? ☐ No XX Yes
13g. ON A FARM? XX ☐ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? XX ☐ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN DZIACHEK
19. MOTHER'S NAME (First, Middle, Maiden Surname): ANNE TUDOR

INFORMANT

20a. INFORMANT'S NAME (Type/Print): TIMOTHY TKACH
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14050 WHIRLAWAY, ORLAND PARK, IL 60467
20c. Relationship: SON

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): AUGUST 13, 2007 ST. MARY CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, INDIANA
22a. EMBALMER'S NAME: HENRY J. BLAKE
22b. EMBALMER'S LICENSE NO.: FDE01019406
23. WAS DEATH REPORTED TO CORONER? XX ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Martin A. Baran
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. ACUTE RESPIRATORY FAILURE — DUE TO (OR AS A CONSEQUENCE OF): — Approximate Interval Between Onset and Death: 3 DAYS

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. — DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: COPD OSTEOPOROSIS ANEMIA

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

CERTIFIER

29a. CERTIFIER (Check only one): XX 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.: 0103480
29d. DATE SIGNED (Month, Day, Year): AUG. 11, 2007

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MAHENDRA A. PATEL, M.D., 835-169TH STREET, HAMMOND, INDIANA 46324

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Bast S.O.
32. DATE FILED (Month, Day, Year): August 15, 2007

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
34e. PLACE OF INJURY—At home, farm, street, factory, 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.

SDH06-004 State Form 10110 (R5/1-99)