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PORTER COUNTY  
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPT.  
155 INDIANA AVENUE  
SUITE 204  
VALPARAISO, IN 46383

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK  
  
DECEDENT

PARENTS  
  
INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED NAME (First Middle Last) <b>SARAH E PATTEN</b>				2. SEX <b>Female</b>		3a. TIME OF DEATH <b>3:30AM</b>		3b. DATE OF DEATH (Month Day Yr) <b>February 8, 1996</b>	
4. SOCIAL SECURITY NUMBER <b>224-44-0137</b>		5a. AGE - Last Birthday (Years) <b>60</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo Day Yr) <b>Apr 24, 1935</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>BEALETON, VA</b>		8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SER. IN U.S. ARMED FORCES <b>NA</b>		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) <b>PORTER MEMORIAL HOSPITAL</b>				9b. CITY TOWN OR LOCATION OF DEATH <b>Valparaiso</b>				9c. COUNTY OF DEATH <b>Porter</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>DOYLE PATTEN, SR.</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOMEMAKER</b>				12b. KIND OF BUSINESS INDUSTRY <b>HOME</b>	
13a. RESIDENCE - STATE <b>IN</b>		13b. COUNTY <b>Lake</b>		13c. CITY TOWN OR LOCATION <b>Hobart</b>		13d. STREET AND NUMBER <b>1407 E. 34TH AVENUE</b>			
13e. ZIP CODE <b>46342</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE - American Indian (Black, White, etc.) (Specify) <b>WHITE</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary/Post-Secondary <b>8</b>				17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)					
18. FATHER'S NAME (First, Middle, Last) <b>WALLACE WILLS ALMOND</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LIZZIE MYRL COPPAGE</b>					
20a. INFORMANT'S NAME (Type/Print) <b>DOYLE PATTEN, SR.</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1407 E. 34TH AVENUE, Hobart, IN 46342</b>				20c. Relationship <b>Husband</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Feb 12, 1996 CHAPEL LAWN MEMORIAL GARDENS</b>				21c. LOCATION - City or Town State <b>Schererville, IN</b>	
22a. EMBALMER'S NAME <b>JAMES J. KRAUSE</b>				22b. EMBALMER'S LICENSE NO. <b>FDO1006463</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>				24b. LICENSE NUMBER (of Licensee) <b>FDO1006463</b>		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342</b>			
26. PART I: Enter the disease, 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) <b>CARCINOMA OF PANCREAS</b> DUE TO (OR AS A CONSEQUENCE OF)  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? (Yes or no) <b>No</b>				28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE FROM TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>A. H. ...</i>		29c. MEDICAL LICENSE NO. <b>01030530</b>		29d. DATE SIGNED (Month Day Year) <b>2.12.96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>ANNESLEY ABY MD, 6040 LUTE ROAD, PORTAGE, IN 46368</b>									
31. HEALTH OFFICER'S SIGNATURE <i>Harry A. ...</i>							32. DATE FILED (Month Day Year) <b>February 13, 1996</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day Year) <b>FEB 16 1996</b>		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no) <b>FEB 16 1996</b>		34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) <b>SAM ORLICH</b>				34f. LOCATION (Street and Number or Rural Route Number City or Town State) <b>AUDITOR LAKE COUNTY</b>					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <b>000574</b>					

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
FEB 15 PM 2:33  
MARSHALLEE CLARK  
RECORDED & INDEXED  
NO

**FILED**

Trotman's 1st Subdiv lot 5 Block 1 except w 70ft  
Unit #06  
Key #16-166-20