This Document Not Valid Unless Stamped on Reverse Side and Embossed with Raised Seal of Porter County

PORTER COUNTY

CERTIFICATE OF DEATH

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

2000 016543

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): ORREN DOUGLAS LILLEY
2. SEX: Male
3a. TIME OF DEATH: 5:34PM
3b. DATE OF DEATH (Month Day Yr): September 27, 1998
4. SOCIAL SECURITY NUMBER: 329-14-6821
5a. AGE - Last Birthday (Years): 75
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): February 8, 1923
7. BIRTHPLACE (City and State or Foreign Country): Watson, Illinois
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: Unavailable
9a. PLACE OF DEATH (Check only one. See Instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Porter Memorial Hospital
9c. CITY TOWN OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marilyn P. Conner
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Owner/Operator
12b. KIND OF BUSINESS INDUSTRY: Self-Employed
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 2500 W. Old Ridge Road
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): John D. Lilley
19. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Hutchins

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Marilyn P. Lilley
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2500 W. Old Ridge Road, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): September 30, 1998 Evergreen Memorial Park
21c. LOCATION - City or Town State: Hobart, Indiana
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road Hobart, IN 46342

CAUSE OF DEATH

28. 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. Renal Failure — 4 yrs
DUE TO (OR AS A CONSEQUENCE OF)
b. Chronic Obstructive Lung Disease — 4 yrs
DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any which gave rise to the immediate cause stating the underlying cause last
c. Sleep Apnea — 4 yrs
DUE TO (OR AS A CONSEQUENCE OF)
d. Coronary Artery Disease — 4 yrs

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.
WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
29a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

CERTIFIER

29a. CERTIFIER (Check only one): [X] 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: [signature]
29c. MEDICAL LICENSE NO: 24841
29d. DATE SIGNED (Month Day Year): 9/29/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): Kenneth A. Black MD, Portage Community Hospital, 3630 Willowcreek Road, 1st Fl, Portage, IN 46368

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary A. Babcoke MD
32. DATE FILED (Month Day Year): September 29, 1998
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: 60789
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): 9.00 E.P.
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

FILED MAR 08 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

2000 MAR -8 AM 9:11

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

STOP

TICOR TITLE INSURANCE Crown Point Indiana
992058 Hes
K#17-35-52

25x10