THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

FEB 22, 2000 — Date Issued — Hammond Health Commissioner

* 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. 95

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): LYNN J. (BUD) McLAUGHLIN
2 SEX: MALE
3a TIME OF DEATH: 4:00P M
3b DATE OF DEATH (Month Day Yr): JANUARY 21, 2000
4 *SOCIAL SECURITY NUMBER: 310-38-6119
5a AGE—Last Birthday (Years): 63
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): OCT. 13, 1936
7 BIRTHPLACE (City and State or Foreign Country): CHICAGO, ILLINOIS
8a WAS DECEDENT A US VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number): ST. MARGARET MERCY HEALTHCARE CENTER/
9c CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): NEVER MARRIED/
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): BUSINESSMAN
12b KIND OF BUSINESS/INDUSTRY: SERVICE STATION
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: WHITING
13d STREET AND NUMBER: 1600 CLEVELAND AVENUE
13e ZIP CODE: 46394
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): JAMES L. McLAUGHLIN
19 MOTHER'S NAME (First Middle Maiden Surname): MARY E. LYNN

INFORMANT

20a INFORMANT'S NAME (Type/Print): MISS THERESE McLAUGHLIN
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1600 CLEVELAND AVE., WHITING, IN 46394/
20c Relationship: SISTER

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JANUARY 25, 2000 CALVARY CEMETERY
21c LOCATION—City or Town, State: PORTAGE, INDIANA
22a EMBALMER'S NAME: MARTIN A. DYBEL
22b EMBALMER'S LICENSE NO: FDE 01019456
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FDE01019456
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: BARAN-FESON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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. Hypertensive Heart disease
DUE TO (OR AS A CONSEQUENCE OF): b.
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? (Yes or no): N/A
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):
☒ 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: 01042343
29d DATE SIGNED (Month Day Year): JAN. 24, 2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SATISH PATEL, M.D., 5500 HOHMAN AVENUE, HAMMOND, INDIANA 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Dremeda M.D.
32 DATE FILED (Month Day Year): JANUARY 27, 2000

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, 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.

99300 9.00 12943

FILED 2000 MAY -1 — PEGGY HOLINGA KATONA, LAKE COUNTY AUDITOR — 2000 029217 — FILED FOR RECORD, MORRIS W. CARTER, RECORDER

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SDH06 004 State Form 10110 (R4/3-93) Deathcer/PD 1