ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal."

Local No. 8008-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

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)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
CHARLES	J	O'BRIEN	Male	11:29 PM	January 2, 2003

4. ★SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
487-40-5852	62			July 24, 1940	JEFFERSON CITY, MO

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
Yes	1967

PLACE OF DEATH (Check only one See instructions)

HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA

OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Anthony Medical Center	Crown Point	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY
Married	KATHLEEN F SCHENHOFER	COMTROLLER	AMERICAN WATER

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	CROWN POINT	912 SENECA DRIVE

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE — American Indian, Black, White, etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46307-	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARLES LEO O'BRIEN	DOROTHY SPRENGER

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
KATHLEEN F. O'BRIEN	912 SENECA DRIVE, CROWN POINT, IN 46307	WIFE

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	January 6, 2003 CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
CRAIG B. MALONE	FD01022392	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Terrence P. Burke	FD1013890	BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana

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 Coronary Syndrome — DUE TO (OR AS A CONSEQUENCE OF):

b. Renal Failure — DUE TO (OR AS A CONSEQUENCE OF):

c. Congestive Glomerulonephritis — DUE TO (OR AS A CONSEQUENCE OF):

d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death: a. Minutes; b. Weeks; c. Yrs.

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

Dischemic Cardiomyopathy; Type 2 Diabetes Mellitus

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE STATEMENT? (Yes or no)
No	No	No

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Daniel J Motyka DO	28003	01-03-03

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print)	31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
DANIEL J MOTYKA, DO 300 W 80TH PLACE, MERRILLVILLE, IN 46410	Daniel J Motyka D.O	January 3, 2003

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

34e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

34f. [illegible] and the number of 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.
January 2, 2003	

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

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COMMUNITY TITLE COMPANY
FILE NO 27312