

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

Local No. 565-04

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

INFORMANTS

DISPOSITION

USE OF

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Marion W. Balding 2 SEX Male 3a TIME OF DEATH 1:05 P 3b DATE OF DEATH (Month, Day, Yr) February 27, 2004

4 *SOCIAL SECURITY NUMBER 359-30-2175 5a AGE—Last Birthday (Years) 66 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Mo, Day, Yr) Nov. 8, 1937 7 BIRTHPLACE (City and State or Foreign Country) Lincoln County, IL.

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 [X] Inpatient [] ER/Outpatient [] DOA [] OTHER [] Nursing Home [] Other (Specify) [] Residence []

9b FACILITY NAME (If not institution, give street and number) Methodist Hospital-Southlake Campus 9c CITY, TOWN OR LOCATION OF DEATH Merrillville 9d COUNTY OF DEATH Lake

10 MARITAL STATUS (Specify) Married 11 SURVIVING SPOUSE (If wife, give maiden name) Joyce O'Brien 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Electrician 12b KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Steel Manufacturing

13a RESIDENCE—STATE Indiana 13b COUNTY Lake 13c CITY, TOWN OR LOCATION Griffith 13d STREET AND NUMBER 307 N. Oakwood Drive

13e ZIP CODE 46319 13f INSIDE CITY LIMITS [] No [X] Yes 13g ON A FARM? [X] No [] Yes 14 CITIZEN OF WHAT COUNTRY? U.S.A. 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) 12 Elementary/Secondary (0-12) College (1-4 or 5+)

18 FATHER'S NAME (First Middle Last) Sherman Balding 19 MOTHER'S NAME (First Middle, Maiden Surname) Carmen Rigg

20a INFORMANT'S NAME (Type/Print) Joyce Balding 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 N. Oakwood Dr. Griffith, In. 46375 20c Relationship Wife

21a METHOD OF DISPOSITION [X] Burial [] Entombment [] Cremation [] Removal from State [] Donation [] Other (Specify) 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) March 3, 2004 Memory Lane Memorial Park 21c LOCATION—City or Town, State Schererville, Indiana

22a EMBALMER'S NAME Leonard Gregorczyk 22b EMBALMER'S LICENSE NO. FDO8800305 23 WAS DEATH REPORTED TO CORONER? [X] No [] Yes

24a SIGNATURE OF FUNERAL DIRECTOR David A. Peltier 24b LICENSE NUMBER (of Licensee) FDO8601585 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, In. 46322 FH1030002

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 each on a separate line. THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. IMMEDIATE CAUSE OF DEATH: HYPOTENSION AND ARTERIO SCLEROSIS DUE TO (OR AS A CONSEQUENCE OF) MYELOFIBROSIS DUE TO (OR AS A CONSEQUENCE OF) SEPSIS DUE TO (OR AS A CONSEQUENCE OF) STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? NO 28a WAS AN AUTOPSY PERFORMED? NO 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A

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) as stated

29b SIGNATURE AND TITLE OF CERTIFIER [Signature] MD 29c MEDICAL LICENSE NO. D104294D 29d DATE SIGNED (Month, Day, Year) MARCH 1, 2004

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) N. GUPTA, 929 RIDGE RD, MUNSTER IN 46321

31 HEALTH OFFICER'S SIGNATURE [Signature] 32 DATE FILED (Month, Day, Year) March 2, 2004

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 000492 9:00 LP \$1,000 copy cash

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.