

20 + 2 Free

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 2565-03
585814

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

Key # 7-30-8 + 64

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED - NAME (First, Middle, Last) James E. Rex		2. SEX Male	3a. TIME OF DEATH 10:40 AM	3b. DATE OF DEATH (Month, Day, Yr.) October 29, 2003	
4. *SOCIAL SECURITY NUMBER 303-46-6523	5a. AGE - Last Birthday (Years) 57	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo., Day, Yr.) January 21, 1946	
7. BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana		8a. WAS DECEASENT A U.S. VETERAN? Yes			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1967		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)			
9d. FACILITY NAME (If not institution, give street and number) St. Anthony Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point		9b. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Kaye M. Plohg	12a. DECEASENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Owner/Construction		12b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Construction	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Crown Point	13d. STREET AND NUMBER 7580 W. 117th		
13e. ZIP CODE 46307-	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEASENT 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) White	
17. DECEASENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Kenneth Monroe Rex			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Cecelia Podkul		20a. INFORMANT'S NAME (Type/Print) Kaye M. Rex			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7580 W. 117th Crown Point IN 46307-		20c. Relationship Wife			
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) Burial		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 1, 2003 Chapel Lawn Memorial Gardens		21c. LOCATION - City or Town, State Schererville, Indiana	
22a. EMBALMER'S NAME Michelle L. Tracy		22b. EMBALMER'S LICENSE NO. FD29700007		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Michelle L. Tracy</i>		24b. LICENSE NUMBER (of Licensee) FDO9000013		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home 109 N. East St., Crown Point, Indiana 46307- FH19900060	
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 fulminant Edeine DUE TO (OR AS A CONSEQUENCE OF): b. Renato-renal syndrome DUE TO (OR AS A CONSEQUENCE OF): c. hepatic failure DUE TO (OR AS A CONSEQUENCE OF): d. metabolic encephalopathy PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				Approximate Interval Between Onset and Death	
27. WAS DECEASENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b. WERE AUTOPSY FINDINGS AVAILABLE TO CORONER COMPLETELY OF DEATH? (Yes or no) No	
29a. CERTIFIER (Check only one) <input 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>Bernardo S. Lucena</i>			29c. MEDICAL LICENSE NO. 0123438	29d. DATE SIGNED (Month, Day, Year) 10/31/03	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/print) Bernardo S. Lucena MD 1121 S. Indiana Ave. Crown Point, IN 46307					
31. HEALTH OFFICER'S SIGNATURE <i>William J. But. D.O.</i>					
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
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.			

DECEDENT

PARENTS

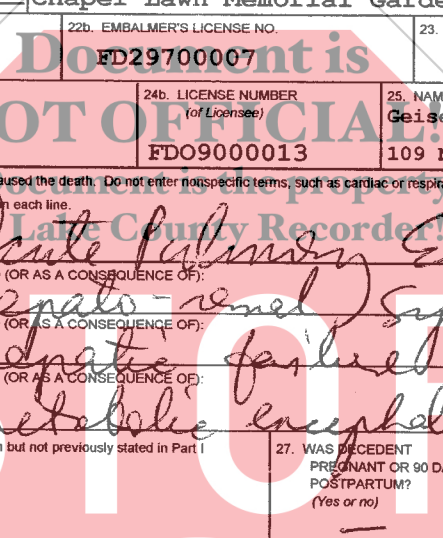
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



FILED
JAN 26 2005
STEPHEN R. STOUGH
LAKE COUNTY AUDITOR

001294
10/31/03