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PORTER COUNTY CERTIFICATE OF DEATH

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

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

SUPPLEMENTAL

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

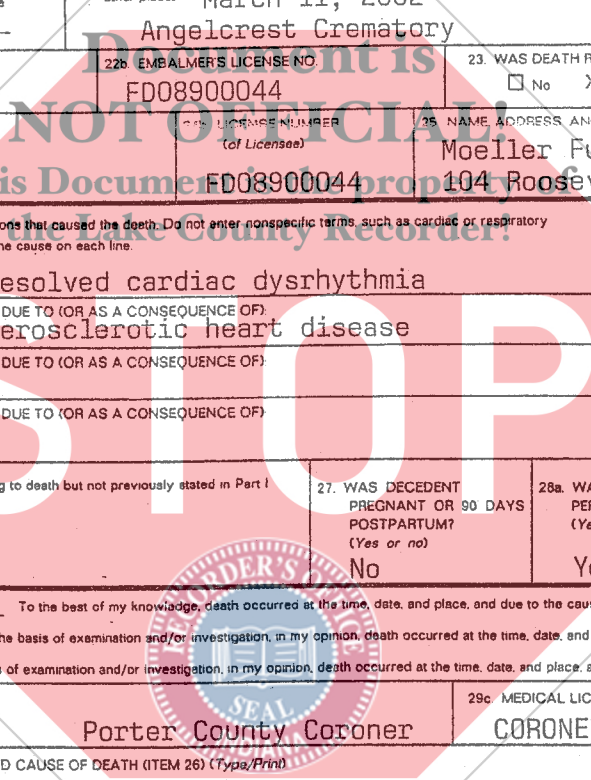
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Michael S. Rogers				2. SEX Male		3a. TIME OF DEATH 10:05P M		3b. DATE OF DEATH (Month, Day, Yr.) March 06, 2002			
4. SOCIAL SECURITY NUMBER 311-62-7016		5a. AGE—Last Birthday (Years) 45		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) AUG 17, 1956		7. BIRTHPLACE (City and State or Foreign Country) Gary, IN	
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: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence							
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) Nancy Johnson		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SR. Technical Svc Coord				12b. KIND OF BUSINESS/INDUSTRY Industrial			
13a. RESIDENCE—STATE IN		13b. COUNTY Porter		13c. CITY, TOWN, OR LOCATION Valparaiso			13d. STREET AND NUMBER 1505 Beech Street				
13e. ZIP CODE 46383		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT 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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 12 College (1-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last) Joseph Rogers						19. MOTHER'S NAME (First, Middle, Maiden Surname) Sally Henderson					
20a. INFORMANT'S NAME (Type/Print) Nancy Rogers				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Beech St., Valparaiso, IN 46383				20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 11, 2002 Angelcrest Crematory				21c. LOCATION—City or Town, State Valparaiso, IN			
22a. EMBALMER'S NAME William A. Higbie				22b. EMBALMER'S LICENSE NO. FD08900044		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes					
24. SIGNATURE OF FUNERAL DIRECTOR <i>William A. Higbie</i>				24b. LICENSE NUMBER (of Licensee) FD08900044		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Moeller Funeral Home FH83006821 104 Roosevelt, Valparaiso, IN 46383					
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. Unresolved cardiac dysrhythmia DUE TO (OR AS A CONSEQUENCE OF) b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.  PART II Other significant conditions—Conditions contributing to death but not previously stated in Part I Cardiomegaly											
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No				28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes				28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes			
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 checked="" 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>Roger L. Kleist</i> Porter County Coroner						29c. MEDICAL LICENSE NO. CORONER		29d. DATE SIGNED (Month, Day, Year) April 05, 2002			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Roger L. Kleist, 155 Indiana Avenue, Valparaiso, IN 46383											
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Behrke</i>								32. DATE FILED (Month, Day, Year) April 5, 2002			
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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.							



Vertical stamp: MICHAEL S. ROGERS, PORTER COUNTY HEALTH DEPARTMENT, REC'D APR 11 2002, APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE FOR RECORDING

Handwritten notes: 200, 4247, T-H