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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

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)
JOHN R. SILLS	Male	4:25PM	November 13, 2005

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)
309-22-6388	72			March 13, 1933	Paris, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1956	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☒ Residence Hospice (Other specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Horton VNA Hospice Center	Valparaiso	Porter

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	Betty J. Dooley	Carpenter	Construction

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Porter	Portage	5053 Marquette

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16. RACE - American Indian Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46368	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John C. Sills	Martha Myers

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
Betty J. Sills	5053 Marquette, Portage, IN 46368	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 ☐ Removal from State ☐ Donation ☐ Other (Specify)	November 16, 2005 McCool Cemetery	Portage, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FD01006463	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Joshua R. Krause	FD29700036	83005613 Rees Funeral Home. Olson Chapel 5341 Central Avenue, Portage, IN 46368

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Metastatic Neuroendocrine Cancer	15 Months
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

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

Metastatic Brain Cancer

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (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) and manner 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) and manner 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)
Barbara L. Fuller, M.D.	0103401	11/15/05

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Barbara L. Fuller Md, 801 MacArthur Blvd, Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE — Mary A. Schneider, MD

32. DATE FILED (Month Day Year) — November 15 2005

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. LOCATION (Street and Number or Rural Route Number City or Town, State)
HAXES: 4451 E. 29th Ave	Hobart, IN 46342

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

Parcel # 42-17-277-47

002506

Prescribed by the
State Board of Accounts
(2005)

County form 170

Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do herby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number in attached document.

2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.

Betty Sills
Signature of Declarant

BETTY SILLS
Printed Name of Declarant