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04-05-0058-0028

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

INDIANA STATE DEPARTMENT OF HEALTH
STATE OF INDIANA
CERTIFICATE OF DEATH LAKE COUNTY State No.
FILED FOR RECORD 0013

Local No. 2044-05

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

PARENTS

INFORMANT

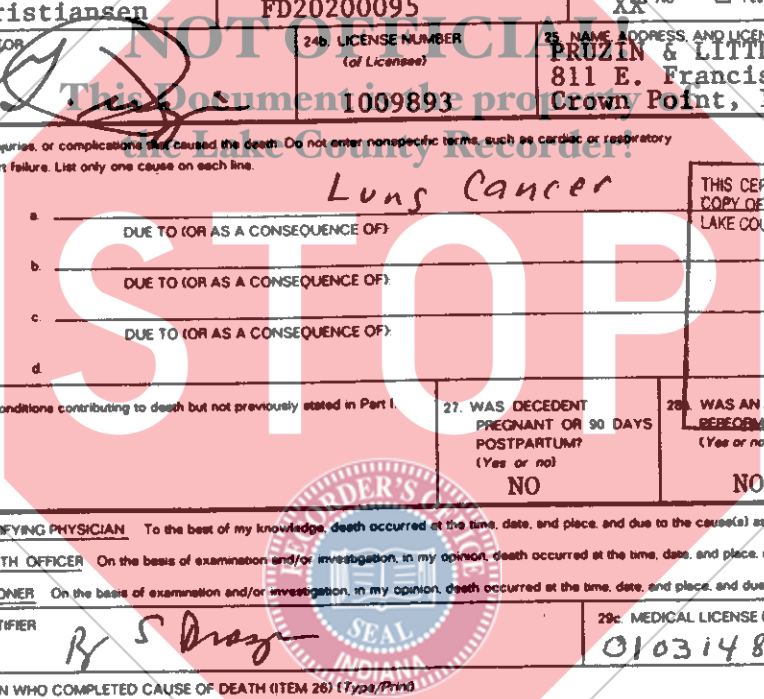
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) SHIRLEY 2006 009654		2. SEX Female		3a. TIME OF DEATH 2006 FEB 16 PM 4:08		3b. DATE OF DEATH (Month, Day, Yr.) July 31, 2005	
4. SOCIAL SECURITY NUMBER 315-40-8152		5a. AGE—Last Birthday (Years) 65		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes Seconds	
6. DATE OF BIRTH (Mo, Day, Yr) MAY 1, 1940		7. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois					
8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) 14718 Georgia Street			9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point			9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) John H. Lindemer		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Crown Point		13d. STREET AND NUMBER 14718 Georgia Street	
13e. ZIP CODE 46307		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 (0-12) 4 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Frank Surchik					
19. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Otto						20. MARLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14718 Georgia St., Crown Point, IN 46307	
20c. Relationship Husband		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)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 4, 2005 West Creek Cemetery		21c. LOCATION—City or Town, State Lowell, Indiana	
22a. EMBALMER'S NAME Jonathon R. Christensen		22b. EMBALMER'S LICENSE NO. FD20200095		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) 1009893		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PROZIN & LITTLE FUNERAL SERVICE 811 E. Franciscan Dr. #83001261 Crown Point, Indiana 46307			
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. Lung Cancer		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A	
26. PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I.		29a. CERTIFIER (Check only one) <input checked="" 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 R. S. Drasga		29c. MEDICAL LICENSE NO. 01031484		29d. DATE SIGNED (Month, Day, Year) 08/02/05			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Drasga, Ray E. M.D. 1205 South Main Street, Crown Point, IN 46307		31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) August 03, 2005			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 FEB 06 2006		34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34f. LOCAL HEALTH OFFICER (Name, Title, Address, Phone) PEGGY HOLINGA-KATONAU #02521 LAKE COUNTY AUDITOR			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
FEB 06 2006

FILED

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 hereby 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.




Signature of Declarant

JOHN LINDEMER
Printed Name of Declarant