

This Document Not Valid Unless Stamped on Reverse Side and Embossed With Raised Seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

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

TYPE/PRINT IN PERMANENT BLACK INK

2 DECEDENT

PARENTS INFORMANT

DISPOSITION

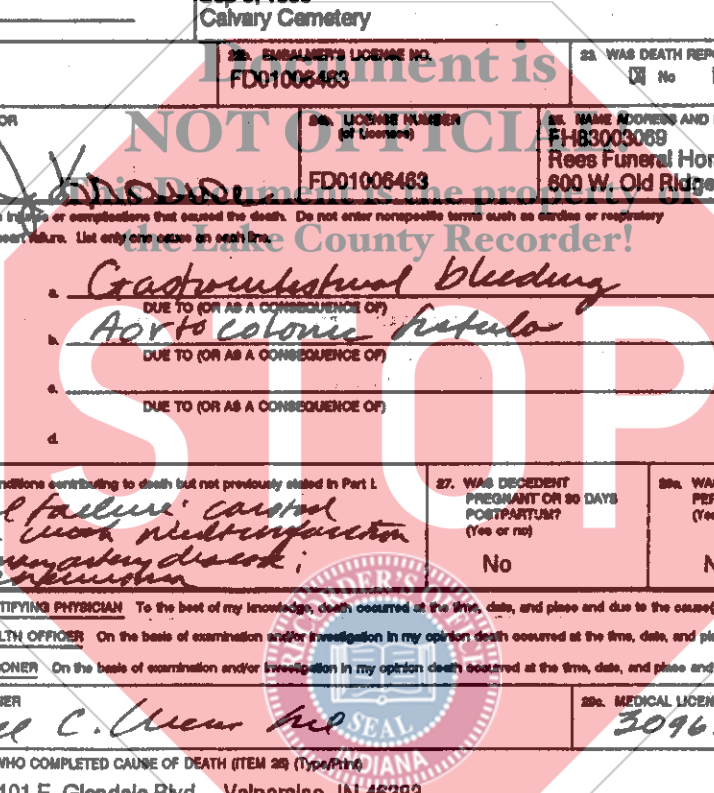
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

HOLD FOR THE TALON GROUP

1. DECEASED NAME (First Middle Last) MARL L. MILLION		2. SEX Male	3a. TIME OF DEATH 9:00PM	3b. DATE OF DEATH (Month Day Yr) September 5, 1996	
4. SOCIAL SECURITY NUMBER 430-24-0271	5a. AGE - Last Birthday (Years) 76	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Aug 9, 1920	
7a. WAS DECEDENT A U.S. VETERAN? Yes	7b. YEAR LAST SERVED IN U.S. ARMED FORCES 1944	7. BIRTHPLACE (City and State or Foreign Country) Pocahontas, Arkansas			
8a. FACILITY NAME (If not institution, give street and number) Porter Memorial Hospital		8b. CITY TOWN OR LOCATION OF DEATH Valparaiso		8c. COUNTY OF DEATH Porter	
9a. WAS DECEDENT US. VET? Yes	9b. YEAR LAST SERVED IN U.S. ARMED FORCES 1944	9c. 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) <input type="checkbox"/> Residence			
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Marcella J Kreul	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Boilermaker	12b. KIND OF BUSINESS INDUSTRY Steel		
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Lake Station	13d. STREET AND NUMBER 2427 Warrick Street		
13e. ZIP CODE 46405	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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 any highest grade completed) Elementary/High School (0-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) William David Million			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Essie Melissa Johnson		20. INFORMANT'S NAME (Type/Print) Marcella Million			
21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 Warrick Street, Lake Station, IN 46405		22. Relationship Wife			
23a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		23b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sep 9, 1996 Cavalry Cemetery		23c. LOCATION - City or Town State Portage, Indiana	
24a. EMBALMER'S NAME James J. Krause		24b. EMBALMER'S LICENSE NO. FD01006463	24c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
25a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		25b. LICENSE NUMBER (of license) FD01006463	25c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. 600 W. Old Ridge Road, Moberg, IN 46342		
26. PART I Enter the disease, trauma, 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) Cardiovascular bleeding DUE TO (OR AS A CONSEQUENCE OF) Aorto colonic fistula DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Chronic renal failure, cerebral artery disease, weak myocardium, degenerative coronary artery disease, Asymptomatic atherosclerosis					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		
29. 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.					
30. SIGNATURE AND TITLE OF CERTIFIER <i>Michael C. Welas MD</i>			30a. MEDICAL LICENSE NO. 30965	30b. DATE SIGNED (Month Day Year) September 9, 1996	
31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Michael C. Welas MD, 1101 E. Glendale Blvd., Valparaiso, IN 46383					
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Baber</i>			32. DATE FILED (Month Day Year) September 9, 1996		
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) FEB 07 2006	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED 11- L.P.
35a. PLACE OF INJURY - All home, farm, street, factory, office building, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR			35b. LOCATION (Street and Number or Rural Route Number City or Town State) 002547TJ		
36. DATE PRONOUNCED DEAD (Month, Day, Year)		37. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



2000-09-10 009702
MICHAEL A. BROWN
RECORDED
2000-FEB-17 12:29 PM
REC'D
ST. JAMES
CLERK
DIARY
RECORD

FILED

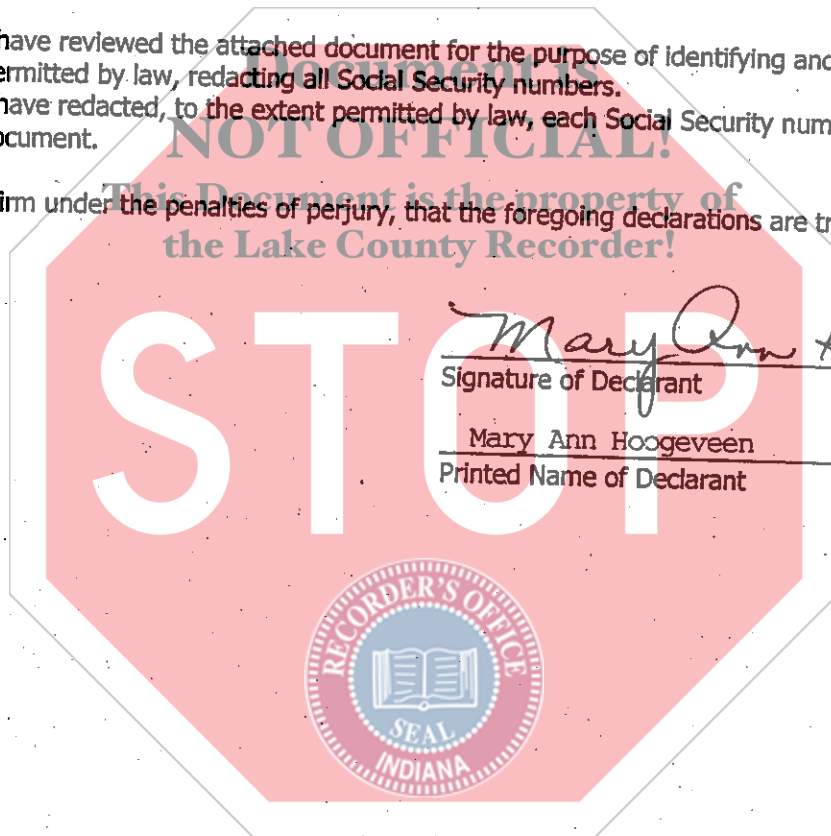
Declaration

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

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



Mary Ann Hoogeveen
Signature of Declarant

Mary Ann Hoogeveen
Printed Name of Declarant