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.

Local No. 4097-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	ROY I. FALKENBERG
2. SEX	MALE
3a. TIME OF DEATH	5:50 AM
3b. DATE OF DEATH (Month, Day, Yr)	DECEMBER 12, 2005
4. *SOCIAL SECURITY NUMBER	[redacted]
5a. AGE—Last Birthday (Years)	82
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	JUNE 26, 1923
7. BIRTHPLACE (City and State or Foreign Country)	NORTHFIELD, MN
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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number)	6013 E. 125TH AVENUE
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)	RITA F. FLYNN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	GENERAL FOREMAN
12b. KIND OF BUSINESS/INDUSTRY	IRONWORKERS UN.395
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	CROWN POINT
13d. STREET AND NUMBER	6013 E. 125TH AVENUE
13e. ZIP CODE	46307
13f. INSIDE CITY LIMITS	☒ No ☐ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	IVER FALKENBERG
19. MOTHER'S NAME (First, Middle, Maiden Surname)	PETRA HELGREN

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	RITA F. FALKENBERG
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	6013 E.125TH AVE., CROWN POINT, IN 46307
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	DECEMBER 16, 2005 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State	MERRILLVILLE INDIANA
22a. EMBALMER'S NAME	TERRENCE P. BURNS
22b. EMBALMER'S LICENSE NO.	1013890
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James T. Burns (signature)
24b. LICENSE NUMBER (of Licensee)	1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BURNS FUNERAL HOME, 10101 BROADWAY CROWN POINT, IN 46307 FDH83002445

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. Cardiorespiratory failure

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

d. DUE TO (OR AS A CONSEQUENCE OF):

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

Field	Entry
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)	N/A

CERTIFIER

29a. CERTIFIER (Check only one)

- XX CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) 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) 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Nadria Ahmed (signature)
29c. MEDICAL LICENSE NO.	01097385A
29d. DATE SIGNED (Month, Day, Year)	12/13/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DR. NADRIA AHMED, 8695 CONNECTICUT ST., SUITE E, MERRILLVILLE, IN 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Susan W Best D.O. (signature)
32. DATE FILED (Month, Day, Year)	December 13, 2005

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.	

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. DEC 13 2005

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2006 FEB -8 PM 3:12 MICHAEL A. BROWN RECORDER

2006 009006

FILED FEB 08 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

11-ZP 12898 27260

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP

RECORDER'S OFFICE SEAL INDIANA

Prescribed by the
State Board of Accounts
(2005)

County form 170

Declaration

Document is
NOT OFFICIAL!
This Document is the property of
the Lake County Recorder!
STOP

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.

Signature of Declarant

Benjamin T. Ballou

Printed Name of Declarant