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

Local No. 01035-04

# INDIANA STATE DEPARTMENT OF HEALTH OR MERIDIAN TITLE CORP

## CERTIFICATE OF DEATH

State No. 10716LK06

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

| | | | | | |
|---|---|---|---|---|---|
| 1 DECEASED—NAME (First, Middle, Last): Arnold T. Smith | | 2 SEX: Male | 3a TIME OF DEATH: 6:05 PM | 3b DATE OF DEATH (Month, Day, Yr): September 3rd 2004 | |
| 4 SOCIAL SECURITY NUMBER: [redacted]5396 | 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): March 10th 1928 | 7 BIRTHPLACE (City and State or Foreign Country): Chicago, IL | |
| 8a WAS DECEDENT A U.S. VETERAN? Yes | 8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1951 | 9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence | | | |
| 9b FACILITY NAME (If not institution, give street and number): Sebo's Nursing and Rehab | | 9c CITY, TOWN, OR LOCATION OF DEATH: Hobart | 9d COUNTY OF DEATH: Lake | | |
| 10 MARITAL STATUS (Specify): Married | 11 SURVIVING SPOUSE (If wife, give maiden name): Norma | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machinist | 12b KIND OF BUSINESS/INDUSTRY: Steel | | |
| 13a RESIDENCE—STATE: Indiana | 13b COUNTY: Lake | 13c CITY, TOWN, OR LOCATION: Gary | 13d STREET AND NUMBER: 1437 E. 51st Avenue | | |
| 13e ZIP CODE: 46409 | 13f INSIDE CITY LIMITS ☐ No ☒ Yes; 13g ON A FARM? ☒ No ☐ Yes | 14 CITIZEN OF WHAT COUNTRY: USA | 15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 12; College (1-4 or 5+): |
| 18 FATHER'S NAME (First, Middle, Last): BArdy Smith | | 19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Jones | | | |
| 20a INFORMANT'S NAME (Type/Print): Norma Smith | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1437 E. 51st Ave. Gary, IN 46409 | | 20c Relationship: Wife | | |
| 21a METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 9th 2004 Kraft Funeral Service | 21c LOCATION—City or Town, State: Hobart, Indiana | | | |
| 22a EMBALMER'S NAME: Christopher Podgorski | 22b EMBALMER'S LICENSE NO: FD29300030 | 23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes | | | |
| 24a SIGNATURE OF FUNERAL DIRECTOR | 24b LICENSE NUMBER (of Licensee): FD29300030 | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Christopher Funeral Home, Inc. FH19500025 1307 Central Ave. Lake Station, IN 46405 | | | |

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 Carcinoma

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF): Carcinoma @ Lung
c. DUE TO (OR AS A CONSEQUENCE OF): Hypertension
d. DUE TO (OR AS A CONSEQUENCE OF): Hypertensive Heart Disease

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

| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) | 28a WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|
| NO | NO | N/A |

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) 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

| 29b SIGNATURE AND TITLE OF CERTIFIER | 29c MEDICAL LICENSE NO | 29d DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Timothy | IN25043 | 9/15/2004 |

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr K. Potti 8300 Broadway Merrillville, IN 219-769-4616

31 HEALTH OFFICER'S SIGNATURE: Susan D Bat M.D.

32 DATE FILED (Month, Day, Year): 9/20/2004

FILED
FEB 14 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

| 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)

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT (Yes or no) If yes, driver, passenger, pedestrian, etc.

SEP 15 2004

003164

SDH06-004 State Form 10110 (R5/1-99)

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.

"VERIFIED FOR RECORDING BY MERIDIAN TITLE"



Tammy DePra
Signature of Declarant

Tammy DePra
Printed Name of Declarant