

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

DEPRINT IN PERMANENT BLACK INK
DECEASED
RENTS
FORMANT
POSITION
CERTIFIER
HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) **Lisper Lee Lewis**

2. SEX **Male** 3a. TIME OF DEATH **9:39 A M** 3b. DATE OF DEATH (Month, Day, Yr.) **September 13, 2002**

4. SOCIAL SECURITY NUMBER **[REDACTED]-0891** 5a. AGE--Last Birthday (Years) **85** 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Mo. Day, Yr.) **December 13, 1916** 7. BIRTHPLACE (City and State or Foreign Country) **Owensboro, Kentucky**

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 Residence Other (Specify)

9b. FACILITY NAME (If not institution, give street and number) **Methodist Hospital Southlake** 9c. CITY, TOWN, OR LOCATION OF DEATH **Merrillville** 9d. COUNTY OF DEATH **Lake**

10. MARITAL STATUS **Married** 11. SURVIVING SPOUSE (If wife, give maiden name) **Ada Cunningham** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Maintenance** 12b. KIND OF BUSINESS/INDUSTRY **Oscar Mayer**

13a. RESIDENCE--STATE **Indiana** 13b. COUNTY **Lake** 13c. CITY, TOWN, OR LOCATION **Merrillville** 13d. STREET AND NUMBER **321 West 54th Place**

13e. ZIP CODE **46410** 13f. INSIDE CITY LIMITS No Yes 14. CITIZEN OF WHAT COUNTRY? **U.S.A.** 15. WAS DECEDENT OF HISPANIC ORIGIN? X No Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. RACE--American Indian, Black, White, etc. (Specify) **Black** 17. DECEDENT'S EDUCATION (Specify only highest grade completed) **Elementary/Secondary (0-12) 12th 14**

18. FATHER'S NAME (First, Middle, Last) **Willie Lewis** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **(Unavailable)**

20a. INFORMANT'S NAME (Type/Print) **Ada Lewis** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **321 West 54th Place Merrillville, Indiana 46410** 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 20, 2002 Washington Memory Gardens Homewood, Illinois**

22a. EMBALMER'S NAME **Sherman G. Banks III** 22b. EMBALMER'S LICENSE NO. **FD 01016254** 23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *[Signature]* 24b. LICENSE NUMBER (of Licensee) **FD 01016254** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Smith Bizzell & Warner Funeral Home, FH19600034 4209 Grant St. Gary, IN. 46408**

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) **Pneumonia**

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

Coronoma of Colon

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No Yes 28a. WAS AN AUTOPSY PERFORMED? (Yes or No) No Yes 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) No Yes

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 *[Signature]* 29c. MEDICAL LICENSE NO. **01034378A** 29d. DATE SIGNED (Month, Day, Year) **9/17/02**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Aashad Malik, 8560 Broadway, Merrillville, IN 46410**

31. HEALTH OFFICER'S SIGNATURE *[Signature]* 32. DATE FILED (Month, Day, Year) **11/02/02**

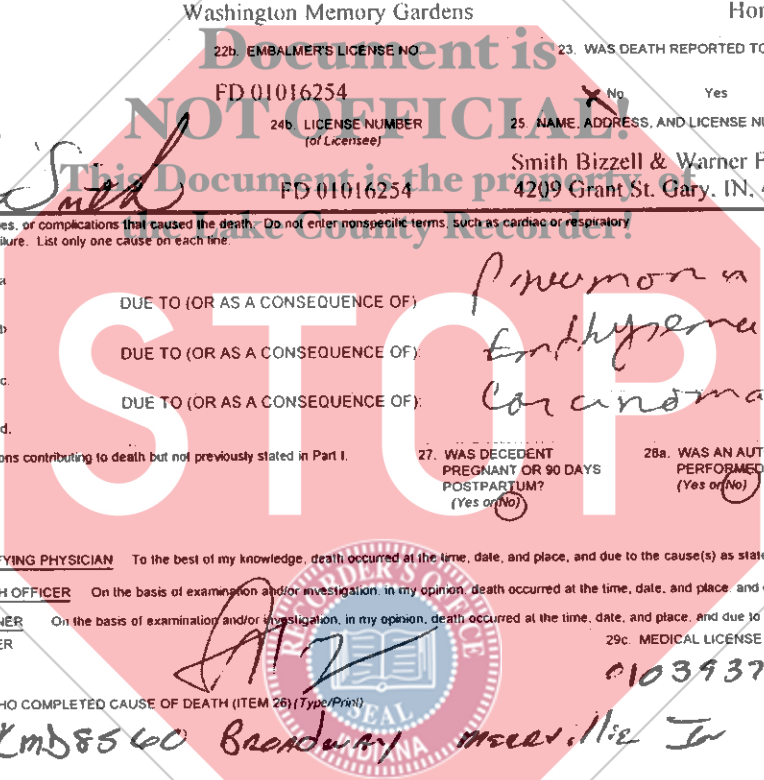
33. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide

34a. DATE OF INJURY (Month, Day, Year) **FEB 27 2006** 34b. TIME OF INJURY 34c. INJURY AT WORK (Yes or no) 34d. DESCRIBE HOW AND WHERE THE DEATH OCCURRED (Type/Print) **LAKE COUNTY HEALTH DEPARTMENT**

34e. PLACE OF INJURY--At home, farm, street, factory, office building, etc. (Specify) **LAKE COUNTY AUDITOR** 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.)

USE OF HEALTH K 30-15-2487



FILED

FEB 21 2006

FEB 27 2006

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

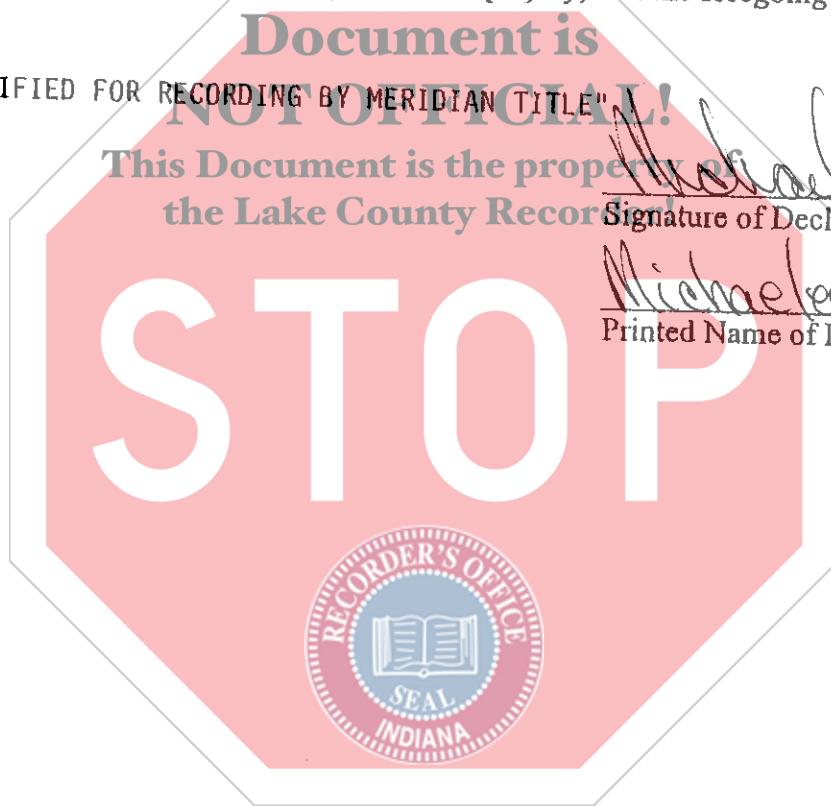
Declaration

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.



"VERIFIED FOR RECORDING BY MERIDIAN TITLE"

This Document is the property of
the Lake County Recorder's Office

Michaelene Z. Fazekas
Signature of Declarant

Michaelene Z. Fazekas
Printed Name of Declarant