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

Local No. 1819-02

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

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: X 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 (Specify): 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 X Yes
13g. ON A FARM?: X No Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): X No Yes
16. RACE--American Indian, Black, White, etc. (Specify): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+)

PARENTS

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

INFORMANT

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

DISPOSITION

21a. METHOD OF DISPOSITION: Entombment / Burial / Cremation / X 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
21c. LOCATION--City or Town, State: Homewood, Illinois
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER?: X 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

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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. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF): b. Emphysema
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF): c. Carcinoma of Colon
DUE TO (OR AS A CONSEQUENCE OF): d.

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
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

CERTIFIER

29a. CERTIFIER (Check only one)
X 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.: 01039378A
29d. DATE SIGNED (Month, Day, Year): 9/17/02
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Arshad Malik MD 8560 Broadway Merrillville In 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Best D.O.
32. DATE FILED (Month, Day, Year): 2002

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
FEB 21 2006

FILED
FEB 27 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

2006 005155

K 36-15-24854

SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1

004203

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"

Signature of Declarant

Michelene I. Fazekas

Printed Name of Declarant

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NOT OFFICIAL!
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STOP
RECORDER'S OFFICE SEAL INDIANA