

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. 03 0859

1200 + 3 FreevETS

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. Parcel # 25-46-115-14

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) John L. Faulkner Jr.		2. SEX Male	3a. TIME OF DEATH 1:30 P	3b. DATE OF DEATH (Month, Day, Year) December 1, 2003
4. SOCIAL SECURITY NUMBER 310-36-6979	5a. AGE—Last Birthday (Years) 70	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) September 20, 1933
7. BIRTHPLACE (City and State or Foreign Country) Sumner, Mississippi	8a. WAS DECEDENT A U.S. VETERAN? YES		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1961	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)
9b. FACILITY NAME (If not institution, give street and number) 959 Matthews Street		9c. CITY, TOWN, OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Lois N. Johnson	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Foreman		12b. KIND OF BUSINESS/INDUSTRY USXC (Sheet & Tin)
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 959 Matthews Street
13a. ZIP CODE 46406	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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) Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0		18. FATHER'S NAME (First, Middle, Last) John L. Faulkner		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Dorn		20. INFORMANT'S NAME (Type/Print) Lois N. Faulkner		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 959 Matthews Street Gary, Indiana 46406		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Enshroument <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 8, 2003 Evergreen Cemetery		21c. LOCATION—City or Town, State Hobart, Indiana
22a. EMBALMER'S NAME Roosevelt Allen Jr.		22b. EMBALMER'S LICENSE NO. #01051701		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) #08700298		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704
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) MI		a. DUE TO (OR AS A CONSEQUENCE OF)		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. DUE TO (OR AS A CONSEQUENCE OF)		
		c. DUE TO (OR AS A CONSEQUENCE OF)		
		d. DUE TO (OR AS A CONSEQUENCE OF)		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I DM				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) 0		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) I don't know		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
29a. 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.				
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. MEDICAL LICENSE NO. 01047536	29d. DATE SIGNED (Month, Day, Year) 12/10/03
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ANDREW STUBBARD 257 W 8th DRIVE MERRILLVILLE, IN 46470				
31. HEALTH OFFICER'S SIGNATURE 				32. DATE FILED (Month, Day, Year) DEC 15 2003
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		33a. DATE OF INJURY (Month, Day, Year)	33b. TIME OF INJURY	33c. AT WORK? (Yes or no)
34a. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34b. LOCATION (Street and Number or Rural Route Number, City or Town, State) 004290		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no, if yes, specify as driver, passenger, pedestrian, etc.) NO		

FILED FEB 27 2006 PEGGY HOLINGA-KATONA LAKE COUNTY AUDITOR

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 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.



Lois W. Fay / Kper
Signature of Declarant

Lois W. Fay / Kper
Printed Name of Declarant