* **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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 06 0131

State No. Parcel # 41-49-293-12

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): Linda K. Evans			2. SEX: Female	3a. TIME OF DEATH: 3:18pm M	3b. DATE OF DEATH (Month, Day, Yr.): March 5, 2006
4. *SOCIAL SECURITY NUMBER: 307-54-7656	5a. AGE—Last Birthday (Years): 58	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr): October 31, 1947	7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
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 [ ] Other (Specify) [ ] Residence	
9b. FACILITY NAME (If not institution, give street and number): Metholist Hospital-Northlake		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): Alford Evans	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker		12b. KIND OF BUSINESS/INDUSTRY: Own Home	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Gary		13d. STREET AND NUMBER: 2531 Stevenson Street	
13e. ZIP CODE: 46406	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? [X] 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): 11	College (1-4 or 5 +): 0		

PARENTS

18. FATHER'S NAME (First, Middle, Last): William Flynn	19. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Bennett

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Alford Evans	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2531 Stevenson Street Gary, Indiana 46406	20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 8, 2006 Calvary Crematory	21c. LOCATION—City or Town, State: Portage, Indiana
22a. EMBALMER'S NAME: Thomas D. Klopfenstein	22b. EMBALMER'S LICENSE NO.: FD29500017	23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas D. Klopfenstein	24b. LICENSE NUMBER (of Licensee): FD29500017	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Ridgelawn Funeral Home 4201 West Ridge Road Gary, Indiana 46408 FH10200007

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

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

		Approximate Interval Between Onset and Death
a.	Hepatic Encephalopathy	
DUE TO (OR AS A CONSEQUENCE OF) b.	Cirrhosis of Liver	
DUE TO (OR AS A CONSEQUENCE OF) c.	Respiratory Failure	
DUE TO (OR AS A CONSEQUENCE OF) d.	Congestive Cardiac Failure	

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

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)

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	29c. MEDICAL LICENSE NO.: IN29043	29d. DATE SIGNED (Month, Day, Year): 3/8/06

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): KRISHNAN [illegible] 8300 BROADWAY Merrillville IN 46410

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year): MAR 0 8 2006

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

FILED MAR 20 2006 REGGY HOLINGA KATONA LAKE COUNTY AUDITOR

$11 005992 CAM

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

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.

Signature of Declarant

Printed Name of Declarant