* **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. 0008-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): WILLIE JOHN LAHNERS
2. SEX: Male
3a. TIME OF DEATH: 10:41 AM
3b. DATE OF DEATH (Month, Day, Yr.): January 4, 2005
4. *SOCIAL SECURITY NUMBER: 469-22-6135
5a. AGE—Last Birthday (Years): 80
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): July 30, 1924
7. BIRTHPLACE (City and State or Foreign Country): Webster, Wisconsin
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
9a. PLACE OF DEATH (Check only one. See instructions.): [X] HOSPITAL: Inpatient; [ ] ER/Outpatient; [ ] DOA; [ ] OTHER: Nursing Home; [ ] Other (Specify); [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): ST.MARGARET-MERCY SOUTH
9c. CITY, TOWN, OR LOCATION OF DEATH: DYER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): M. ALBERTA VINSON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Driver
12b. KIND OF BUSINESS/INDUSTRY: CALUMET LUMBER
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 1034-177TH PLACE
13e. ZIP CODE: 46324
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): 8; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN EDWARD LAHNERS
19. MOTHER'S NAME (First, Middle, Maiden Surname): EVELYN ERICKSEN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): M. ALBERTA LAHNERS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1034-177TH PLACE, HAMMOND, IN 46324
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment; [X] Burial; [ ] Cremation; [ ] Removal from State; [ ] Donation; [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jan 7, 2005 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE IN
22a. EMBALMER'S NAME: JOSE G. CORONA
22b. EMBALMER'S LICENSE NO.: FDO8601373
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John Ault
24b. LICENSE NUMBER (of Licensee): FDO1013507
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BOCKEN FUNERAL HOME, INC. 7042 KENEDY AVENUE, HAMMOND, IN

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)
a. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death: Unknown

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Metastatic Prostate Carcinoma Type III Diabetes mellitus

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: Michael R Olden D.O.
29c. MEDICAL LICENSE NO.: 36-051559
29d. DATE SIGNED (Month, Day, Year): 1/5/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): MICHAEL OLDEN, D.O. 24 JOLIET ST., SUITE 101, DYER, IN 46311

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan M Bast D.O.
32. DATE FILED (Month, Day, Year): January 5 2005

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.

AUG 23 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

FILED
AUG 23 2006
LAKE COUNTY AUDITOR

COMMUNITY TITLE COMPANY
FILE NO 3469-05

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