

This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

INFORMANT

DISPOSITION

USE OF

CERTIFIER

ICER

TICOR MO 920066311

1. DECEASED—NAME (First, Middle, Last) William R. Stanson		2. SEX Male	3a. TIME OF DEATH 2:52 AM	3b. DATE OF DEATH (Month, Day, Yr.) June 22, 2006	
4. *SOCIAL SECURITY NUMBER ██████-8352	5a. AGE—Last Birthday (Years) 73	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) November 25, 1932	
7. BIRTHPLACE (City and State or Foreign Country) Antigo, WI	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: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) Porter Portage Hospital Campus		9c. CITY, TOWN, OR LOCATION OF DEATH Portage	9d. COUNTY OF DEATH Porter		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Sandra J. Miller	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Real Estate Broker		12b. KIND OF BUSINESS/INDUSTRY Real Estate	
13a. RESIDENCE—STATE IN	13b. COUNTY Porter	13c. CITY, TOWN, OR LOCATION Valparaiso		13d. STREET AND NUMBER 731 North Meridian Road	
13e. ZIP CODE 46385	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) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 12 College (1-4 or 5+) 6					
18. FATHER'S NAME (First, Middle, Last) William Stanson		19. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve Young			
20a. INFORMANT'S NAME (Type/Print) Sandra J. Stanson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 N. Meridian Rd., Valparaiso, IN 46385		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) June 26, 2006 Angelcrest Cemetery		21c. LOCATION—City, Town, State Valparaiso, IN	
22a. EMBALMER'S NAME Jason S. Armstrong		22b. EMBALMER'S LICENSE NO. FD29600121	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>William A. Lie</i>		24b. LICENSE NUMBER (of Licensee) FD08900044	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Moeller Funeral Home FH83006821 104 Roosevelt Rd., Valparaiso, IN 46383		
26. PART I. Enter the disease, 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. Heart attack DUE TO (OR AS A CONSEQUENCE OF): b. at bleed DUE TO (OR AS A CONSEQUENCE OF): c. COVD DUE TO (OR AS A CONSEQUENCE OF): d. Orthomyxelt					
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) N/A		
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 <i>Carman</i>		29c. MEDICAL LICENSE NO. 01044934A	29d. DATE SIGNED (Month, Day, Year) 6-26-06		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Abdus Lakhani 2102 E. Evans Ave Ste 110 Valparaiso, IN 46383					
31. HEALTH OFFICER'S SIGNATURE <i>Ray A. Babrook MD</i>			32. DATE FILED (Month, Day, Year) June 28, 2006		
33. MANNER OF DEATH <input 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		34a. DATE OF INJURY (Month, Day, Year) FILED	34b. TIME OF INJURY FILED	34c. INJURY (Specify) FILED	
34d. DESCRIBE HOW INJURY OCCURRED 11-28-TJ		34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) AUG 24 2006			
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		34g. DATE PRONOUNCED DEAD (Month, Day, Year)			
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 016414					