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. 584-03 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): Malinda Jones
2. SEX: Female
3a. TIME OF DEATH: 9:27 P. M
3b. DATE OF DEATH (Month, Day, Yr.): February 27, 2003
4. SOCIAL SECURITY NUMBER: 427-78-9822
5a. AGE-Last Birthday (Years): 61
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): June 07, 1941
7. BIRTHPLACE (City and State or Foreign Country): Blackhawk, Mississippi
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: [ ] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [X] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): Franciscan Community Services
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Theradtric Jones
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Teacher
12b. KIND OF BUSINESS/INDUSTRY: Hammond School System
13a. RESIDENCE-STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 363 Arthur Street
13e. ZIP CODE: 46404
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): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) College (1-4 or 5+): 5

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Allen
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie Austin

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Theradtric Jones
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 363 Arthur Street Gary, Indiana 46404
20c. Relationship: Husband

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): March 06, 2003 Evergreen Memorial Park
21c. LOCATION-City or Town, State: Hobart, IN
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER? [ ] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD20000361
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home FH19600034 4209 Grant St, Gary, IN, 46408

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. metastatic breast cancer — Approximate Interval Between Onset and Death: 4½ years
DUE TO (OR AS A CONSEQUENCE OF):
b.
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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: history left breast cancer 1991 & right breast cancer 1996
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: My Klein MD
29c. MEDICAL LICENSE NO.: 01034294
29d. DATE SIGNED (Month, Day, Year): March 3, 2003
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARY Y KLEIN MD 1190 NORTH STATE ROAD 49 PORTER IND 46304

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Best, D.O.
32. DATE FILED (Month, Day, Year): March 4, 2003

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.

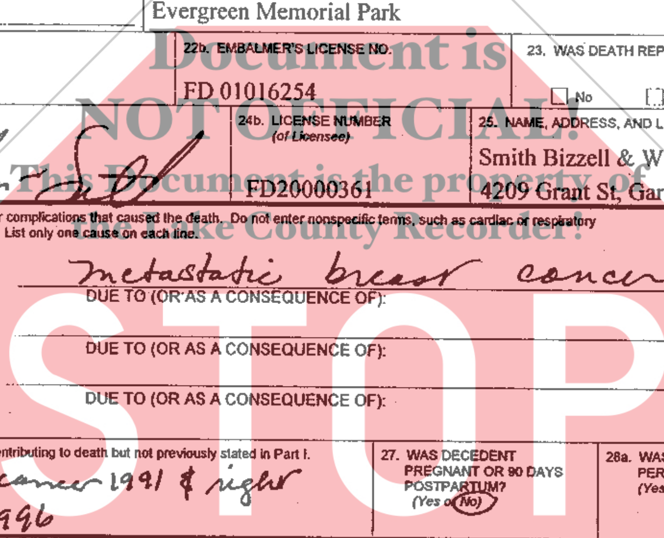
FILED
DEC 28 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

THE ABOVE IS CERTIFIED AS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
DEC 28 2006
026443

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2006 DEC 28 PM 2:4_ MICHAEL A. BROWN RECORDER

2006 113895

Gary Land Co's 4th Sub N 12 ft Lot 2 & S 22 ft of Lot 3 Block 32 28-44-0186-0003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SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1