* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*
Local No. 1272-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 07-17-0248-0125

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): KATHRYN W. PICKERING
2. SEX: Female
3a. TIME OF DEATH: 7:06 PM
3b. DATE OF DEATH (Month, Day, Yr.): May 19, 2007
4. *SOCIAL SECURITY NUMBER: 310-48-3845
5a. AGE - Last Birthday (Years): 62
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): January 12, 1945
7. BIRTHPLACE (City and State or Foreign Country): Hammond Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Dean Pickering
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 2931 Crowsnest Dr.
13e. ZIP CODE: 46342
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): 12; College (1-4 or 5+):

2007 13319

PARENTS

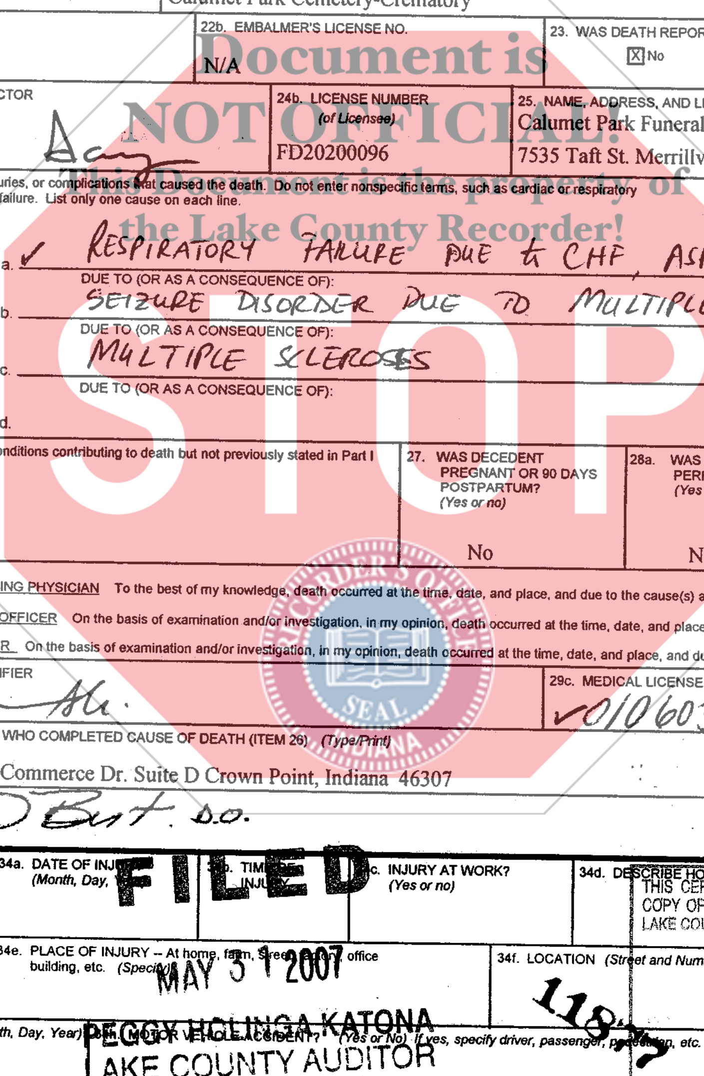
18. FATHER'S NAME (First, Middle, Last): Ralph Hetfield
19. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Begalla

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Dean Pickering
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2931 Crowsnest Dr. Hobart, Indiana 46342
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 22, 2007 Calumet Park Cemetery-Crematory
21c. LOCATION - City or Town, State: 2305 West 73rd St. Merrillville, Indiana 46410
22a. EMBALMER'S NAME: N/A,.
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Robert A. Agy
24b. LICENSE NUMBER (of Licensee): FD20200096
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Calumet Park Funeral Chapel FH10400032 7535 Taft St. Merrillville, Indiana 46410



STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2007 MICHAEL A. BROWN RECORDER

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	RESPIRATORY FAILURE DUE to CHF, ASPIRATION PNEUMONIA	2-3 days
DUE TO (OR AS A CONSEQUENCE OF): b.	SEIZURE DISORDER DUE TO MULTIPLE SCLEROSIS	5 days
DUE TO (OR AS A CONSEQUENCE OF): c.	MULTIPLE SCLEROSIS	Many years
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:
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: Asrar Ali
29c. MEDICAL LICENSE NO.: 01060322A
29d. DATE SIGNED (Month, Day, Year): 5-21-07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Asrar Sheikh M.D. 5265 Commerce Dr. Suite D Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W. Burt D.O.
32. DATE FILED (Month, Day, Year): May 21, 2007

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):
MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

FILED MAY 31 2007 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
MAY 21 2007

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11.00 S.D.M. CS

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