TTENTION ESTATE: The Social Security # is ng requested by this state agency in order to sue its statutory responsibility. Disclosure is untary and there will be no penalty for refusal.

cal No. 2721-06

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

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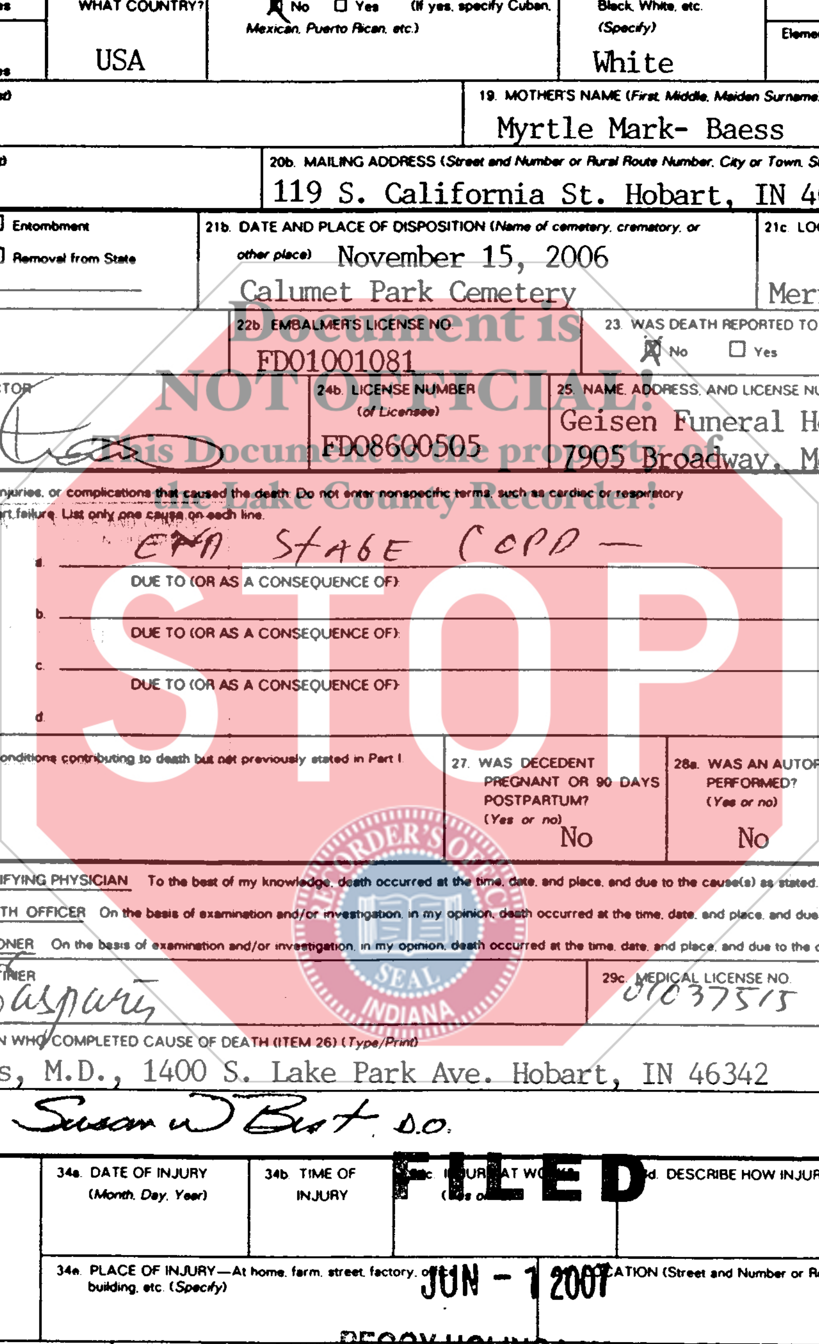

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CEDENT

1. DECEASED—NAME (First, Middle, Last): Kenneth William Mark
2. SEX: Male
3a. TIME OF DEATH: 11:29p. M
3b. DATE OF DEATH (Month, Day, Yr.): November 12, 2006
4. SOCIAL SECURITY NUMBER: 312-16-0567
5a. AGE—Last Birthday (Years): 84
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): November 2, 1922
7. BIRTHPLACE (City and State or Foreign Country): Johnston City, Illinois
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
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): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): ---
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Crane operator
12b. KIND OF BUSINESS/INDUSTRY: Operating Engineers Local 150
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 119 S. California Street
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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+):

RENTS

18. FATHER'S NAME (First, Middle, Last): Oden Mark
19. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Mark- Baess

ORMANT

20a. INFORMANT'S NAME (Type/Print): Nancy Granger
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 119 S. California St. Hobart, IN 46342
20c. Relationship: Daughter

POSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 15, 2006 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Ronald Reed
22b. EMBALMER'S LICENSE NO.: FD01001081
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD08600505
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, IN 46410

USE OF ATH

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. END STAGE COPD —
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

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

Approximate Interval Between Onset and Death:

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): ---

TICOR HBT

TIFIER

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: Milton Gasparis
29c. MEDICAL LICENSE NO.: 01037515
29d. DATE SIGNED (Month, Day, Year): Nov 14 06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Milton Gasparis, M.D., 1400 S. Lake Park Ave. Hobart, IN 46342

LTH ICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Best D.O.
32. DATE FILED (Month, Day, Year): November 15, 2006

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 JUN - 1 2007 PEGGY HOLINGA KATONA

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