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. 480-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 03-07-0195-0003

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED –NAME (First, Middle, Last): George W Stoutenour
2. SEX: Male
3a. TIME OF DEATH: 12:01 P M
3b. DATE OF DEATH (Month, Day, Year): February 25, 2007
4. SOCIAL SECURITY NUMBER: 334-24-7628
5a. AGE - Last Birthday (Years): 77
5b. UNDER 1 YEAR – Months / Days:
5c. UNDER 1 DAY – Hours / Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): January 3, 1930
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 10/10/1951
9a. PLACE OF DEATH (Check only one. See Instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not Institution, give street and number): 11730 Burr
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): Patricia Machielson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done most of working life. Do not use retired): Auto Mechanic
12b. KIND OF BUSINESS/INDUSTRY: Auto Retail
13a. RESIDENCE- STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 11730 Burr
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Clinton Stoutenour
19. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Radtke - Stoutenour

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Pat Stoutenour
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11730 Burr Crown Point, IN 46307
20c. RELATIONSHIP: Wife

DISPOSITION

21a. BURIAL, CREMATION, ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other(Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 28, 2007 Kelly -Carrol Cremation Svc
21c. LOCATION - City or Town, State: Gary, IN
22a. EMBALMER'S NAME:
22b. EMBALMERS LICENSE NO.:
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of licensee): FD29300070
25. NAME AND ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Boersma Funeral Home FH10000109, 90 East Grove Street Wheatfield, IN 46392

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. CONGESTIVE HEART FAILURE, PROGRESSIVE
DUE TO (OR AS A CONSEQUENCE OF):
b. CHRONIC KIDNEY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. COPD
DUE TO (OR AS A CONSEQUENCE OF):
d. MULTIPLE ABDOMINAL SURGERIES

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

Approximate Interval Between Onset and Death

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

JUN 07 2007

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)
☒ 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: Marek Odehnal, MD
29c. MEDICAL LICENSE NO.: 01060578A
29d. DATE SIGNED (Month, Day, Year): 2/26/2007

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print): Marek Odehnal MD 10200 Wicker Ave St. John IN 46373
31. HEALTH OFFICER SIGNATURE: Susan M Bitz D.O.
32. DATE FILED (Month,Day,Year): February 26, 2007 11:00 A.M. CS

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. 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 or pedestrian, etc.

FILED JUN 07 2007 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

SDH06-004 State Form 10110-04 (R5/1-993)

11954