* 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. 438-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ______

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED-NAME (First, Middle, Last)	Billy D. Chronister
2. SEX	Male
3a. TIME OF DEATH	12:50 AM
3b. DATE OF DEATH (Month, Day, Yr.)	February 20, 2007
4. SOCIAL SECURITY NUMBER	496-48-8820
5a. AGE-Last Birthday (Years)	60
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr.)	June 10, 1946
7. BIRTHPLACE (City and State or Foreign Country)	Cabool, Missouri
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 ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	Munster, IN
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Judy K. Lovan
12a. DECEDENT S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Chemical Lab Tester
12b. KIND OF BUSINESS/INDUSTRY	Steel Manufacturing
13a. RESIDENCE-STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hammond
13d. STREET AND NUMBER	7520 Alexander Avenue
13e. ZIP CODE	46323
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. AS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Harold Chronister
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Gladys Rimmel

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Judy K. Chronister
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7520 Alexander Avenue, Hammond, IN 46323
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	February 26, 2007 Willow Springs Cemetery
21c. LOCATION-City or Town, State	Willow Springs, MO
22a. EMBALMER'S NAME	Timothy Bowler
22b. EMBALMER'S LICENSE NO	FD20500035
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	C.A. Kuiper
24b. LICENSE NUMBER (of Licensee)	FD01014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Kuiper Funeral Home, 9039 Kleinman Road, Highland, IN 46322 — FH10300021

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.	Pulmonary Hypertension Severe	months
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.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	H Alan Jones DO
29c. MEDICAL LICENSE NO	02000640
29d. DATE SIGNED (Month, Day, Year)	2-21-07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	H. ALAN JONES, D.O. 929 Ridge Road Munster, IN 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Susan W Bert, DO
32. DATE FILED (Month, Day, Year)	Feb 21 2007

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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 11 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

FEB 21 2007

$11

COMMUNITY TITLE COMPANY
FILE NO 37491

007711

2007 036135

SDH06-004 State Form 10110 (R5/1-99)