



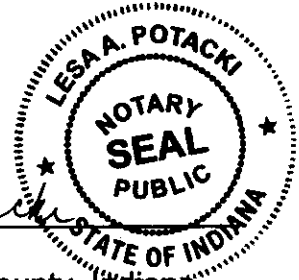
STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Janice Budack, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 17 day of October, 2006.

My commission expires: 02/03/2010

Signature: Lesa A. Potacki  
Lesa A. Potacki  
Resident of: Lake County, Indiana

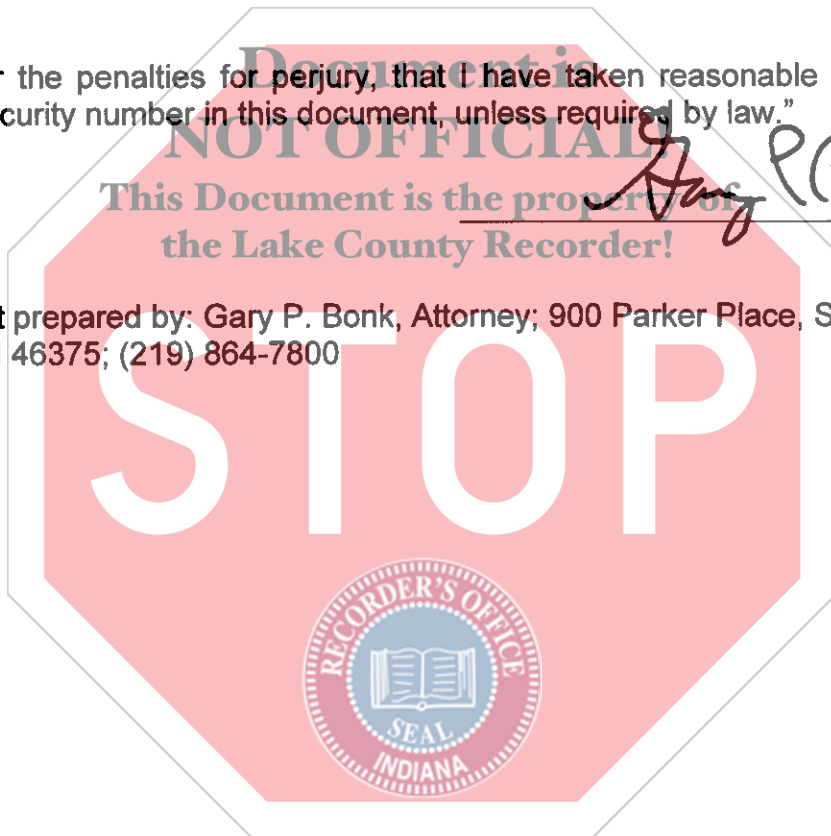


"I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law."

**NOT OFFICIAL**  
This Document is the property of  
the Lake County Recorder!

Gary P. Bonk

This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800



\* 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

Local No. 866-06 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

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) <b>Eli George Budack II</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>5:30 P</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>April 03, 2006</b>
4. *SOCIAL SECURITY NUMBER <b>311-36-3544</b>	5a. AGE-Last Birthday (Years) <b>69</b>	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) <b>October 24, 1936</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>East Chicago, Indiana</b>		8a. PLACE OF DEATH (Check only one. See instructions.)		
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
9a. FACILITY NAME (If not institution, give street and number) <b>Community Hospital</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>		9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Janice Sorrels</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Mechanic</b>
12b. KIND OF BUSINESS/INDUSTRY <b>Ozinga Trucking</b>		13a. RESIDENCE-STATE <b>Indiana</b>		
13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Griffith</b>		13d. STREET AND NUMBER <b>405 East Avenue H</b>
13e. ZIP CODE <b>46319</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE-American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		18. FATHER'S NAME (First, Middle, Last) <b>Eli Budack</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Silion</b>		20a. INFORMANT'S NAME (Type/Print) <b>Janice Budack</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 East Avenue H Griffith, Indiana 46319</b>		20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>April 07, 2006 Chapel Lawn Memorial Gardens</b>		21c. LOCATION-City or Town, State <b>Schererville, Indiana</b>
22a. EMBALMER'S NAME <b>Steven J. Struck</b>		22b. EMBALMER'S LICENSE NO. <b>FD08600181</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Steven J. Struck</i>		24b. LICENSE NUMBER (of Licensee) <b>FD08600181</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Chapel Lawn Funeral Home, FH19900051 8178 Cline Avenue, Schererville, Indiana, 46375</b>
26. PART I. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> 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. <b>a. Indocarbimide &amp; embolism DUE TO (OR AS A CONSEQUENCE OF):</b> <b>b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c.  DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.  DUE TO (OR AS A CONSEQUENCE OF):</b>		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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or No) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) <b>No</b>
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>02001332</b>
29d. DATE SIGNED (Month, Day, Year) <b>4/6/06</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>KENDELL L. OETTER, D.O., 505 W. LINCOLN HIGHWAY, SCHERERVILLE, IN 46375</b>		
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) <b>April 7 2006</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>JUN 12 2007</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT (Yes or no) If yes specify driver, passenger, pedestrian, etc.		