

\* 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

CERTIFICATE OF DEATH

State No. ....

Local No. #06-444

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

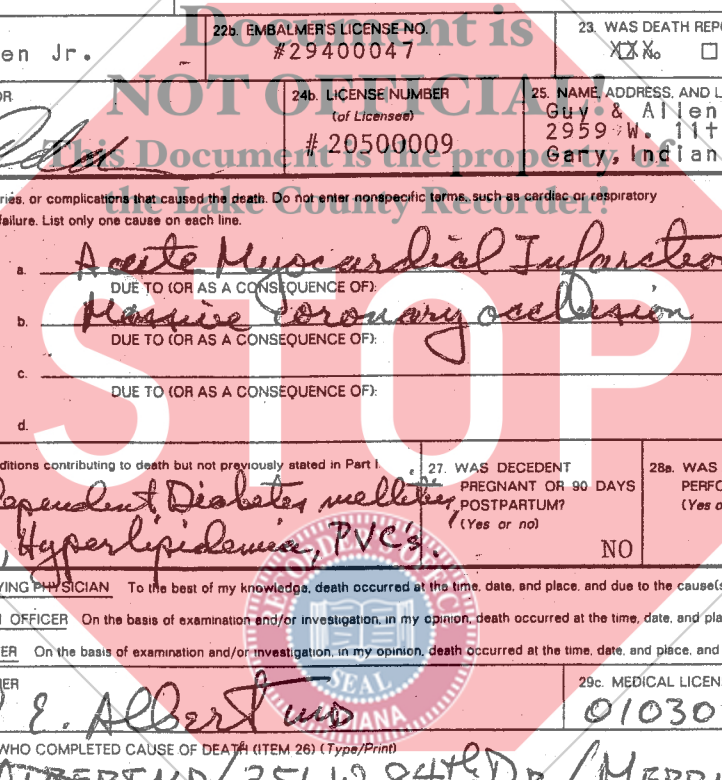
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

|  |  |   |  |   |
|--|--|---|--|---|
| 1. DECEASED—NAME (First, Middle, Last)<br>Albert English Jr.   |  | 2. SEX<br>Male  | 3a. TIME OF DEATH<br>8:05 A <sub>M</sub>   | 3b. DATE OF DEATH (Month, Day, Yr.)<br>August 20, 2006                                  |
| 4. SOCIAL SECURITY NUMBER<br>723-18-7320   |  | 5a. AGE—Last Birthday (Years)<br>74   | 5b. UNDER 1 YEAR<br>Months Days  | 5c. UNDER 1 DAY<br>Hours Minutes  |
| 6. DATE OF BIRTH (Mo, Day, Yr)<br>October 24, 1931   |  | 7. BIRTHPLACE (City and State or Foreign Country)<br>Gary, Indiana  |  |   |
| 8a. WAS DECEDENT A U.S. VETERAN?<br>NO   | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?<br>N/A  | 9a. PLACE OF DEATH (Check only one. See instructions)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence |  |   |
| 9b. FACILITY NAME (If not institution, give street and number)<br>Methodist Hospital Northlake   |  | 9c. CITY, TOWN, OR LOCATION OF DEATH<br>Gary  | 9d. COUNTY OF DEATH<br>Lake  |   |
| 10. MARITAL STATUS (Specify)<br>Married  | 11. SURVIVING SPOUSE (If wife, give maiden name)<br>Donna M Lamb                               | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br>Larry Car Operator   | 12b. KIND OF BUSINESS/INDUSTRY<br>USX Steel Corp.  |   |
| 13a. RESIDENCE—STATE<br>Indiana  | 13b. COUNTY<br>Lake  | 13c. CITY, TOWN, OR LOCATION<br>Gary  | 13d. STREET AND NUMBER<br>2338 Jennings Street   |   |
| 13e. ZIP CODE<br>46404   | 13f. INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14. CITIZEN OF WHAT COUNTRY?<br>U S A   | 15. WAS DECEDENT OF HISPANIC ORIGIN?<br><input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)               | 16. RACE—American Indian, Black, White, etc. (Specify)<br>Black                         |
| 17. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+)   |  | 17. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>8th  |  |   |
| 18. FATHER'S NAME (First, Middle, Last)<br>Albert English Sr.  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mae Chambers   |  |   |
| 20a. INFORMANT'S NAME (Type/Print)<br>Donna M. English   |  | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2338 Jennings Street Gary, Indiana 46404   | 20c. Relationship<br>Wife  |   |
| 21a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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)<br>August 25, 2006<br>Evergreen Cemetery   |  | 21c. LOCATION—City or Town, State<br>Hobart Indiana                                     |
| 22a. EMBALMER'S NAME<br>Rosenwald D. Allen Jr.   |  | 22b. EMBALMER'S LICENSE NO.<br>#29400047  | 23. WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  |   |
| 24a. SIGNATURE OF FUNERAL DIRECTOR<br><i>[Signature]</i>   |  | 24b. LICENSE NUMBER (of Licensee)<br>#20500009  | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br>Guy & Allen Funeral Directors, Inc<br>2959 W. 11th Avenue<br>Gary, Indiana 46404 83007704 |   |
| 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.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death)<br>a. <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Massive Coronary occlusion</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>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<br><i>Non Insulin dependent Diabetes mellitus, Hypertension, Hyperlipidemia, PVC's.</i>   |  |   |  |   |
| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)<br>NO   |  | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no)<br>NO  |  | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
| 29. CERTIFIER<br><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.<br><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.<br><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.                           |  |   |  |   |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>Raphael E. Albert MD</i>   |  | 29c. MEDICAL LICENSE NO.<br>01030144  | 29d. DATE SIGNED (Month, Day, Year)<br>8/23/06   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br><i>RADHALE E. ALBERT MD / 251 W. 84th DR / MERRILLVILLE, IN. / 46410</i>   |  |   |  |   |
| 31. HEALTH OFFICER'S SIGNATURE<br><i>[Signature]</i>   |  |   |  | 32. DATE FILED (Month, Day, Year)<br>AUG 30 2006  |
| 33. MANNER OF DEATH<br><input checked="" 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 IT WORKED (Yes or no)   |
| 34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)<br>JUL 11 2007  |  | 34e. DESCRIBE HOW INJURY OCCURRED<br>009209 \$11 CS   |  |   |
| 34g. DATE PRONOUNCED DEAD (Month, Day, Year)   |  | 34h. MOTOR VEHICLE ACCIDENT? (Specify driver, passenger, pedestrian, etc.)<br>LAKE COUNTY AUDITOR   |  |   |

F.R. Maas 1st Add  
Lots 9 & 10 Block 4  
25-46-0004-0009



2007 JUL 11 AM 11:30  
MICHAEL A. BRANN  
RECORDER  
STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORDER  
Approximate Interval Between Onset and Death  
2 years

FILED  
JUL 11 2007  
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR