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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

Local No. 1169-04 State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

2007086962

DECEDENT

1. DECEASED--NAME (First, Middle, Last): Carl F. Muehlman, Jr.
2. SEX: Male
3a. TIME OF DEATH: 9:47 M
3b. DATE OF DEATH (Month, Day, Yr.): May 03, 2004
4. *SOCIAL SECURITY NUMBER: 310-32-3461
5a. AGE--Last Birthday (Years): 69
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): March 01, 1935
7. BIRTHPLACE (City and State or Foreign Country): Hammond
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1957
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: [ ] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [X] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 11120 Cline Avenue
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): Janice Muehlman
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Excavation
12b. KIND OF BUSINESS/INDUSTRY: Excavation
13a. RESIDENCE--STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 11120 Cline Avenue
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [ ] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): Caucasian
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last): Carl F. Muehlman Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Burbich Muehlman

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Janice Muehlman
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11120 Cline Avenue Crown Point, IN 46307
20c. Relationship: Spouse

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 06, 2004 Chapel Lawn Memorial Gardens
21c. LOCATION--City or Town, State: Schererville, Lake
22a. EMBALMER'S NAME: Jeffery N. Sachs
22b. EMBALMER'S LICENSE NO.: FD29800086
23. WAS DEATH REPORTED TO CORONER? [ ] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD29800086
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Chapel Lawn Funeral Home, 8178 Cline Avenue, Schererville, Indiana, 46375

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. Esophageal Cancer (squamous cell carcinoma/[illegible]) — Approximate Interval Between Onset and Death: 47 days

DUE TO (OR AS A CONSEQUENCE OF):

b. History of tobacco abuse ([illegible] smoking by [illegible]) — decades

DUE TO (OR AS A CONSEQUENCE OF):

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

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Aphasia due to cerebrovascular accident 1998. History of alcohol abuse chronically [illegible]. Likely mechanism of death: hemorrhage of esophageal tumor [illegible] adjacent Aorta, but cannot be proven without autopsy

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)

05-06-0008-0020 Pt E½ NE 80 rods X 236.38 ft S.10 T.34 R.9 7.228AC

CERTIFIER

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: [signature] MD
29c. MEDICAL LICENSE NO.: 01016970A
29d. DATE SIGNED (Month, Day, Year): May 5 2004
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SPENCER J MARKOVITZ, MD 13963 MORSE ST. CEDAR LAKE, IN 46303

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] D.O.
32. DATE FILED (Month, Day, Year): May 6, 2004

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 DEC - 6 2007 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1