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ATTENTION ESTATE: The Social Security # is ›ing requested by this state agency in order to ırsue its statutory responsibility. Disclosure is ›luntary and there will be no penalty for refusal.

ocal No... 2555-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 08-15-07920014

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

YPE/PRINT IN ƎRMANENT ƁLACK INK

DECEDENT

1. DECEASED–NAME (First, Middle, Last): Mark Everard Hudson
2. SEX: Male
3a. TIME OF DEATH: 8:01 P M
3b. DATE OF DEATH (Month, Day, Year): October 10, 2007
4. *SOCIAL SECURITY NUMBER: 303-62-8872
5a. AGE – Last Birthday (Years): 51
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): March 11, 1956
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1983
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): Methodist Hospital Southlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Sandra Lockett
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Paralegal
12b. KIND OF BUSINESS/INDUSTRY: Social Security Office
13a. RESIDENCE — STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 9158 Carolina Court
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 1

ARENTS

18. FATHER'S NAME (First, Middle, Last): Thorton James Hudson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Morton

ɪFORMANT

20a. INFORMANT'S NAME (Type/Print): Sandra Hudson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code): 9158 Carolina Court Merrillville, IN 46410
20c. Relationship: Wife

ISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 16, 2007 Evergreen Memorial Park Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD01016254
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell Warner FH10500021 4209 Grant Street Gary, Indiana 46408

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AUSE OF EATH

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. lung cancer

DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory failure

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

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF):

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. OCT 26 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)

ERTIFIER

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: E. Alobaid MD
29c. MEDICAL LICENSE NO.: 01058415A
29d. DATE SIGNED (Month, Day, Year): 10-29-07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. Alobeid 8300 Broadway Merrillville, IN 46410

EALTH ꟻFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Best D.O.
32. DATE FILED (Month, Day, Year): October 26, 200[7]

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 14 2007
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

25134

2007 081900

MICHAEL A. BROWN RECORDER

2007 DEC 14 PM [illegible]

FILED FOR RECORD

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