

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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

State No.

Local No. 2-2-07

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

COMMUNITY TITLE COMPANY
FILE NO 239080

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) Charles E. Van Nada				2. SEX Male	3a. TIME OF DEATH 12:26 PM	3b. DATE OF DEATH (Month, Day, Year) February 1, 2007
4. SOCIAL SECURITY NUMBER 315-07-4094		5a. AGE - Last Birthday (Years) 89	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) June 23, 1917	7. BIRTHPLACE (City and State or Foreign Country) Petersburg IN
8a. WAS DECEDENT A U.S. VETERAN? YES	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) 123 S. Union				9c. CITY, TOWN, OR LOCATION OF DEATH Lowell		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) N/A	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Attorney			12b. KIND OF BUSINESS/INDUSTRY Law Office	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Lowell		13d. STREET AND NUMBER 123 S. Union		
13e. ZIP CODE 46356	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) White	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last) J. Frederick Van Nada				19. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Crowder		
20a. INFORMANT'S NAME (Type/Print) Alison Donaldson			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 830 Shawnee Ave., Lafayette, IN 47905		20c. Relationship Daughter	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) Feb 5, 2007 Heritage Crematory		21c. LOCATION - City or Town, State Portage IN		
22a. EMBALMER'S NAME: N/A		22b. EMBALMER'S LICENSE NO. N/A		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of License) FD08900045	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home FH83004277 604 E. Commercial Ave. Lowell, IN 46356			
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. Complication from surgery				Approximate Interval Between Onset and Death
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. gastro-intestinal bleed				
		c. Colon carcinoma				
		d. Parkinson				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. My peritonitis malnutrition renal insufficiency Metastasis						
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)		
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. 01030234	29d. DATE SIGNED (Month, Day, Year) 2-2-07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Randall Hile MD 1020 E. Commercial Ave., Lowell, IN 46356						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						
32. DATE FILED (Month, Day, Year) JAN 15 2008						
33. MANNER OF DEATH <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. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY JUDITOR		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or No)		34d. DESCRIBE HOW INJURY OCCURRED
34g. DATE PRONOUNCED DEAD (Month, Day, Year) 2-2-07						
34h. TYPE OF VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. 000434						

FILED
JAN 15 2008
PEGGY HOLINGA KATONA
LAKE COUNTY JUDITOR

THIS CERTIFIES THE ABOVE IS A TRUE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT ON FEB 12 2007
000434