6+2

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.

Local No. 889-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Key #(2) 3-186-36

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Cecil Saddler
2. SEX: Male
3a. TIME OF DEATH: 5:15PM
3b. DATE OF DEATH (Month, Day, Yr): April 2, 2007
4. SOCIAL SECURITY NUMBER: 499-44-9520
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Sept. 23, 1941
7. BIRTHPLACE (City and State or Foreign Country): McComas, WV
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1962
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): St. Anthony Medical Center
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): Sandra Tribulak
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Driver
12b. KIND OF BUSINESS/INDUSTRY: Trucking
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lowell
13d. STREET AND NUMBER: 231 W. Lakeview Dr
13e. ZIP CODE: 46356
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): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Cloyd Henry Saddler
19. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Leona Shue

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sandra Saddler
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 231 W. Lakeview Dr Lowell, IN46356
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 6, 2007 St. Casimir Cemetery
21c. LOCATION—City or Town, State: Chicago, IL
22a. EMBALMER'S NAME: David Gaidas
22b. EMBALMER'S LICENSE NO: 03412326
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William E Burdan
24b. LICENSE NUMBER (of Licensee): FD01007697
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burdan Funeral Home FH83002461 12901 Wicker Ave Cedar Lake, IN

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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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Lobar post obstructive pneumonia	6 days
DUE TO (OR AS A CONSEQUENCE OF) b.	Lung cancer (Non small cell)	8 months
DUE TO (OR AS A CONSEQUENCE OF) c.	Tobacco abuse 50 pack-years quit 6/2005	50 years
DUE TO (OR AS A CONSEQUENCE OF) d.		

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

FILED MAR 07 2008

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Hyperlipidemia Hypertension; Lung cancer was stage IV ~~and~~ at time of diagnosis presenting complaint was dyspnea due to malignant pericardial effusion 7/2006

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): No

NATONAL LAKE COUNTY AUDITOR; RECORDER'S OFFICE SEAL INDIANA

CERTIFIER

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: Spencer J Markowitz
29c. MEDICAL LICENSE NO: 01046970A
29d. DATE SIGNED (Month, Day, Year): 04/05/2007

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SPENCER J. MARKOWITZ, MD 830 CEDAR PARKWAY SCHERERVILLE, IN 46375

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan J Burt D.O.
32. DATE FILED (Month, Day, Year): April 5 2007

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

11.00 CS RM

002429

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