

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

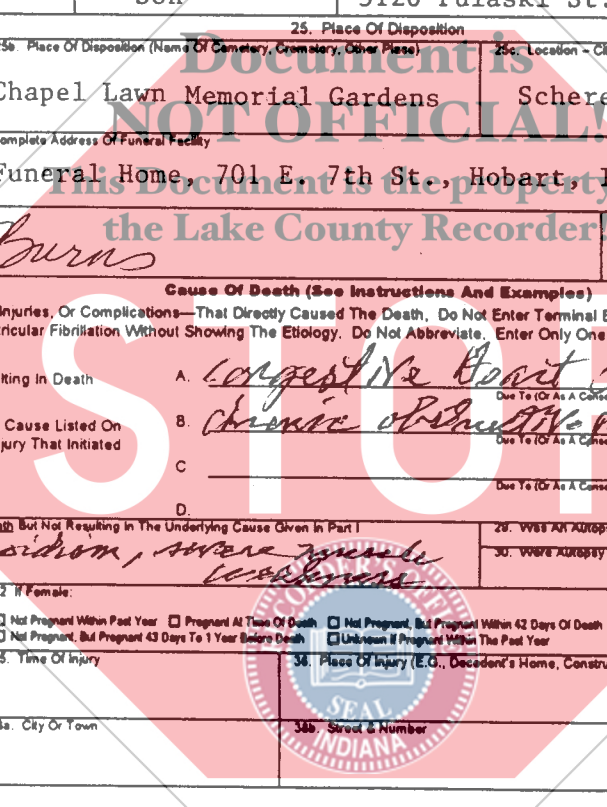
19-21-0083-0028



Local No. 504-08

State No.

1. Decedent's Legal Name (First, Middle, Last) Maxine M. Badger		1s. Maiden Last Name (If Female) Koons		2. Sex F	3. Time Of Death 11:17 am	4. Date Of Death (Month/Day/Year) February 6, 2008	
5. Social Security Number 311-32-1790	6a. Age - Yrs 75	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year) Dec. 11, 1932	8. Birthplace (City And State Or Foreign Country) Logansport, IN
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival		10s. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street And Number) 3120 Pulaski St.							
12. City Or Town, State, And Zip Code Hobart, IN 46342				13. County Of Death Lake		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name N/A		15s. (If Wife) Give Maiden Last Name N/A		16. Decedent's Usual Occupation School Bus Driver		17. Kind Of Business/Industry Transportation	
18. Residence - State Indiana		18a. County Lake		18b. City Or Town Hobart			
18c. Street And Number 3120 Pulaski St.				18d. Apt. No. ----	18e. Zip Code 46342		18f. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
19. Decedent's Education 12		20. Decedent Of Hispanic Origin No		21. Decedent's Race Caucasian			
22. Father's Name (First, Middle, Last) Carl Koons			23. Mother's Name (First, Middle, Last) Leona Koons		23s. Mother's Maiden Last Name Bunnell		
24. Informant's Name Richard L. Badger		24s. Relationship To Decedent Son		24s. Mailing Address (Street And Number, City, State, Zip Code) 3120 Pulaski St., Hobart, IN 46342			
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) Chapel Lawn Memorial Gardens		25c. Location - City, Town, And State Schererville, IN 46375			
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Burns Funeral Home, 701 E. 7th St., Hobart, IN 46342				27s. Funeral Home License Number FH 83002380	
27b. Signature Of Indiana Funeral Service Licensee <i>James F. Burns</i>				27c. License Number (Of Licensee) FD01009461			
28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. congestive heart failure - chronic 1-2 yrs B. chronic obstructive pulmonary disease years C. _____ D. _____ Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last							
29. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I EDM, hypothyroidism, severe muscle weakness				29. WERE AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
30. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined	
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)		37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No. 38d. Zip Code	
39. Describe How Injury Occurred				40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
41. Signature Of Person Certifying Cause Of Death <i>John O. Carter M.D.</i>				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death John O. Carter, M.D., 164 Bracken Parkway, Hobart, IN 46342				44. License Number 01017684		45. Date Certified 2/11/08	
46. Additional Funeral Service Provider PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR				47. *Alias: 3070			
48. Signature of Local Health Officer <i>Susan J. Best, D.O.</i>				49. Date Filed (Month/Day/Year) February 12, 2008			



FILED

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