

\* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.\*

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

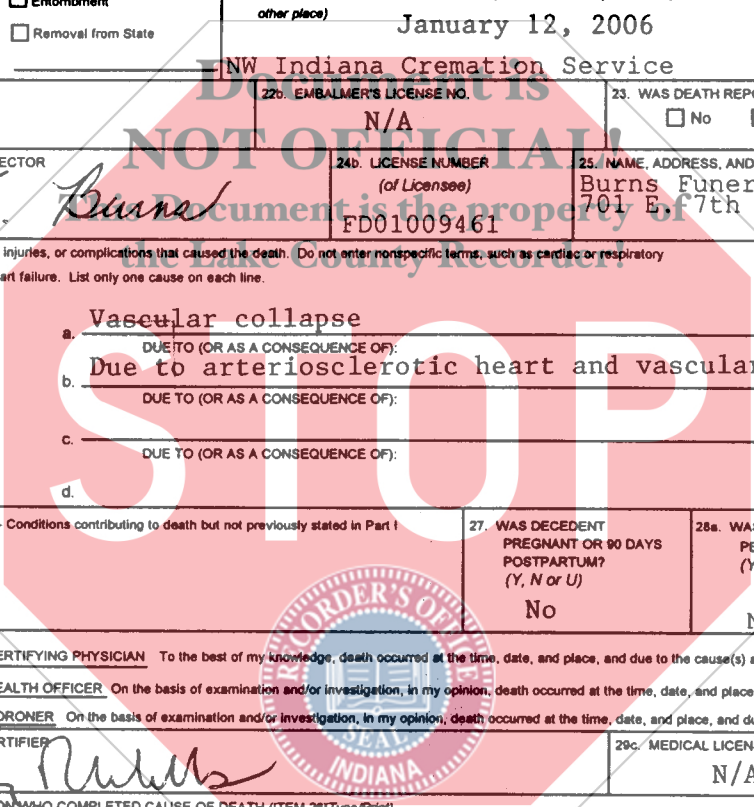
Local No. 0042-06

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK	1. DECEASED - NAME (First, Middle, Last) Steven M. Bartrom			2. SEX Male	3a. TIME OF DEATH 6:50 am	3b. DATE OF DEATH (Month, Day, Yr.) January 10, 2006
	4. * SOCIAL SECURITY NUMBER 304-76-0100	5a. AGE - Last Birthday (Years) 46	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) August 14, 1959	7. BIRTHPLACE (City and State or Foreign Country) Indiana
DECEDENT	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? --	PLACE OF DEATH (Check only one See instructions)			
	9b. FACILITY NAME (If not institution, give street and number) 1520 Howard Ct		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake	
PARENTS	10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Molly P. Miller	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Surveyor		12b. KIND OF BUSINESS/INDUSTRY Zark Zekerez Land	
	13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Hobart		13d. STREET AND NUMBER 1520 Howard Ct	
INFORMANT	13e. ZIP CODE 46342	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) 12 College (1-4 or 5+) N/A
	18. FATHER'S NAME (First, Middle, Last) Ronald T. Bartrom			19. MOTHER'S NAME (First, Middle, Maiden Surname) Marjorie Fitzgerald		
DISPOSITION	20a. INFORMANT'S NAME (Type/Print) Molly P. Bartrom		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1520 Howard Ct., Hobart, IN 46342		20c. Relationship Wife	
	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) January 12, 2006 NW Indiana Cremation Service		21c. LOCATION - City or Town, State Crown Point, Indiana	
CAUSE OF DEATH	22a. EMBALMER'S NAME N/A		22b. EMBALMER'S LICENSE NO. N/A		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
	24a. SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home - PHB3002380 701 E. 7th Street, Hobart, Indiana 46342	
CERTIFIER	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. <u>Vascular collapse</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Due to arteriosclerotic heart and vascular disease</u> c. _____ d. _____  PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					Approximate Interval Between Onset and Death Unknown
	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) 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) ---	
HEALTH OFFICER	29a. CERTIFIER (Check only one) <input 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 checked="" 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>Susan W. Wells</i> Chief Deputy		29c. MEDICAL LICENSE NO. N/A	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) Jeffrey R. Wells, Chief Deputy, 2900 West 93rd Avenue, Crown Point, Indiana 46307					29d. DATE SIGNED (Month, Day, Year) January 11, 2006
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Wells</i>			32. DATE FILED (Month, Day, Year) January 11, 2006			
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"/> Homicide <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) No	34d. DESCRIBE HOW INJURY OCCURRED JUN 7 9 2008 010085	
34e. PLACE OF INJURY - At home, farm, street, factory, building, etc. (Specify) LAKE COUNTY AUDITOR		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) HOLINGA KATONA				
34g. DATE PRONOUNCED DEAD (Month, Day, Year) January 10, 2006		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.				

Glenwood Add to Hobart Unit #7 Not 185 27-17-0250-0021



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