

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

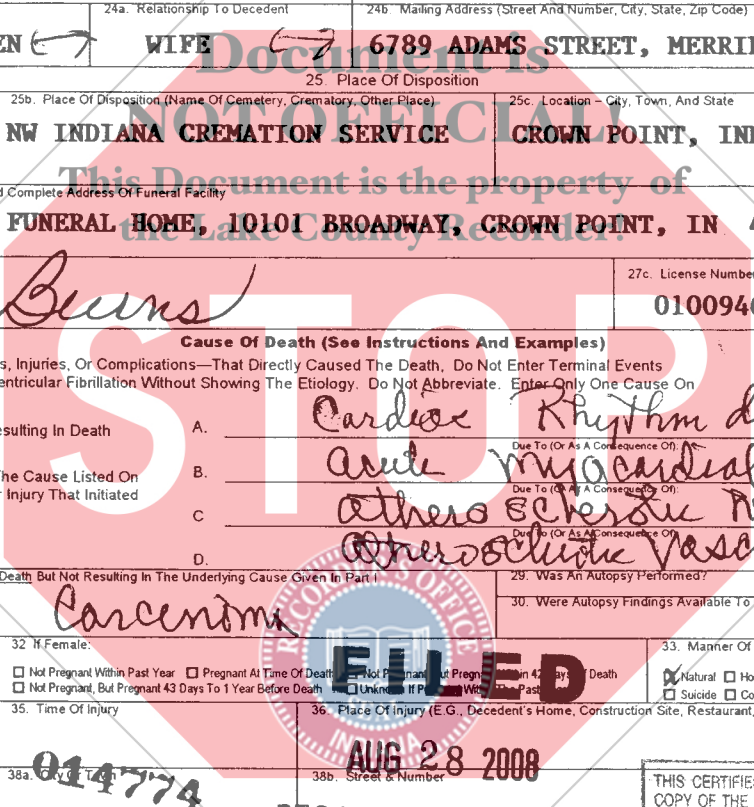


45-12-09-479-008.000-030

Local No. 2861-08

State No. ....

1. Decedent's Legal Name (First, Middle, Last) <b>WILLIAM E. CHRISTIANSEN</b>				1a. Maiden Last Name (If Female) <b>N/A</b>		2. Sex <b>MALE</b>	3. Time Of Death <b>5:42 PM</b>	4. Date Of Death (Month/Day/Year) <b>AUGUST 11, 2008</b>	
5. Social Security Number <b>314-30-1541</b>		6a. Age - Yrs <b>73</b>	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) <b>SEPT. 4, 1934</b>		8. Birthplace (City And State Or Foreign Country) <b>GARY, INDIANA</b>
9. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival				10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input 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) <b>METHODIST HOSPITAL - SOUTLAKE</b>									
12. City Or Town, State, And Zip Code <b>MERRILLVILLE</b>					13. County Of Death <b>LAKE</b>		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name <b>JANETTE M. CHRISTIANSEN</b>			15a. (If Wife) Give Maiden Last Name <b>STOREY</b>		16. Decedent's Usual Occupation <b>TRUCK DRIVER</b>		17. Kind Of Business/Industry <b>7-UP BOTTLING</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>			18b. City Or Town <b>MERRILLVILLE</b>				
18c. Street And Number <b>6786 ADAMS STREET</b>				18d. Apt. No.		18e. Zip Code <b>46410</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education <b>HIGH SCHOOL GRADUATE</b>			20. Decedent Of Hispanic Origin <b>NO</b>		21. Decedent's Race <b>WHITE</b>				
22. Father's Name (First, Middle, Last) <b>PETER CHRISTIANSEN</b>				23. Mother's Name (First, Middle, Last) <b>JENNY CHRISTIANSEN</b>			23a. Mother's Maiden Last Name <b>DAVIDSON</b>		
24. Informant's Name <b>JANETTE M. CHRISTIANSEN</b>		24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>6789 ADAMS STREET, MERRILLVILLE, IN 46410</b>					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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) <b>NW INDIANA CREMATION SERVICE</b>			25c. Location - City, Town, And State <b>CROWN POINT, INDIANA</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>BURNS FUNERAL HOME, 10101 BROADWAY, CROWN POINT, IN 46307</b>				27a. Funeral Home License Number: <b>83002445</b>			
27b. Signature Of Indiana Funeral Service Licensee: <i>James E. Burns</i>					27c. License Number (Of Licensee): <b>01009461</b>				
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. <b>Cardiac Rhythm disturbance</b> <span style="float: right;">Approximate Interval: Onset To Death <b>See</b></span> Due To (Or As A Consequence Of) B. <b>acute myocardial infarction</b> <span style="float: right;"><b>Min</b></span> Due To (Or As A Consequence Of) C. <b>atherosclerotic heart disease</b> <span style="float: right;"><b>weeks</b></span> Due To (Or As A Consequence Of) D. <b>atherosclerotic vascular disease</b> <span style="float: right;"><b>Months</b></span>									
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. <b>Rectal Carcinoma</b>					29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" 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 Before Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within Past Year			33. Manner Of Death: <input checked="" 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) <b>AUG 28 2008</b>		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
38. Location Of Injury - State		38a. Zip Code <b>014774</b>		38b. Street & Number <b>014774</b>		39. Describe How Injury Occurred <b>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR</b>			
41. Signature, Of Person Certifying Cause Of Death: <i>Dennis Streeter</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: <b>DENNIS STREETER, M.D., 119 E. 89TH AVE. MERRILLVILLE, IN 46410</b>						44. License Number <b>02000320</b>		45. Date Certified <b>8-18-08</b>	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <i>Susan W. Best, D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year) <b>August 20, 2008</b>			



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

40. If Transportation Injury, Specify:  
 Driver/Operator  Passenger  Pedestrian  Other (Specify)  
**AUG 28 2008**

*1100  
CASH  
PB*