

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 800-00

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

385239
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

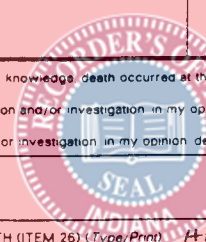
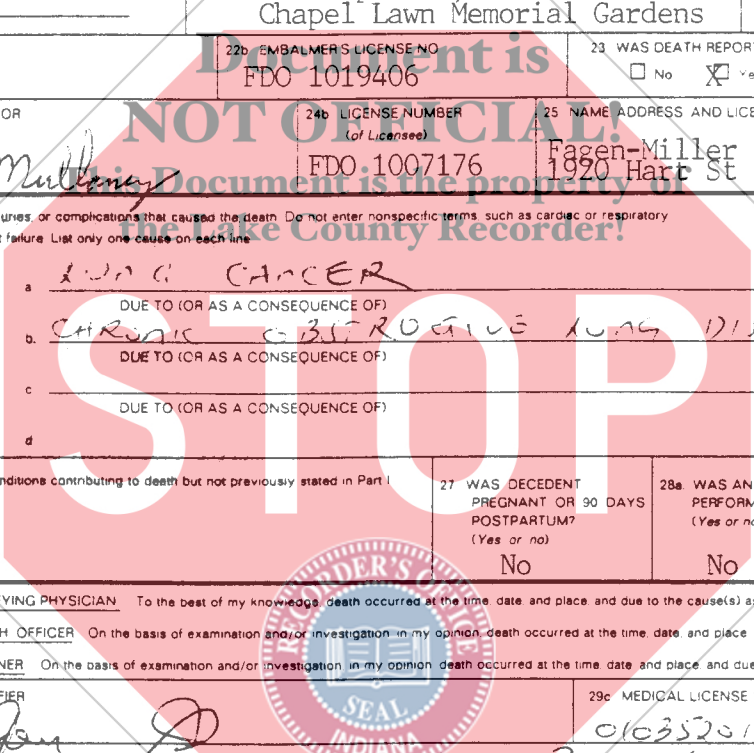
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Clara Elizabeth Arndt		2 SEX Female	3a. TIME OF DEATH 9:10 P M	3b. DATE OF DEATH (Month, Day, Yr) March 29, 2000
4. *SOCIAL SECURITY NUMBER 332-34-4595	5a. AGE—Last Birthday (Years) 57	5b. UNDER 1 YEAR Months 02 Days 05 Hours 05 Minutes	5c. UNDER 1 DAY Hours 05 Minutes	6. DATE OF BIRTH (Mo, Day, Yr) September 3, 1942
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana	8a. WAS DECEDENT A U.S. VETERAN? No			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	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) 708-212th St		9c. CITY, TOWN OR LOCATION OF DEATH Dyer	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Walter A. Arndt	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Management		12b. KIND OF BUSINESS/INDUSTRY Retail
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Dyer	13d. STREET AND NUMBER 708-212th St	
13e. ZIP CODE 46311	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+) 		18. FATHER'S NAME (First, Middle, Last) Elmer Runner		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Gawlik		20a. INFORMANT'S NAME (Type/Print) Walter A. Arndt		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708-212th St Dyer, Indiana 46311		20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) April 1, 2000 Chapel Lawn Memorial Gardens		21c. LOCATION—City or Town, State Schererville, Indiana
22a. EMBALMER'S NAME Henry Blake		22b. EMBALMER'S LICENSE NO. FDO 1019406		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullany</i>		24b. LICENSE NUMBER (of Licensee) FDO 1007176		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes Inc, 1920 Hart St Dyer, Indiana 46311 FH83001504
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. Approximate interval between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. LUNG CANCER		YEARS
Conditions, if any which gave rise to the immediate cause, stating the underlying cause last		b. CHRONIC OBSTRUCTIVE LUNG DISEASE		YEARS
c. _____		d. _____		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I		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>Cynthia J. Sanders</i>		29c. MEDICAL LICENSE NO. 01035201		29d. DATE SIGNED (Month, Day, Year) 3/31/00
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) CYNTHIA J. SANDERS, MASTER, 46321 HAMMOND CLINICAL CALUMET AVE				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>				32. DATE FILED (Month, Day, Year) March 31, 2000
33. MANNER OF DEATH <input 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. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
		34d. DESCRIBE HOW INJURY OCCURRED		FILED 015562
		34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34f. LOCATION (Street and Number, Rural Route Number, City or Town, State) SEP 04 2000
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no. If yes, specify driver, passenger, or pedestrian) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		

45-01-14-277-014-00-003



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