Key # 45-07-22-430-004.000-026

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 955-08 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
Laurence F. Walsh		Male	2:20 AM	March 17, 2008

5. Social Security Number	6a. Age Yrs	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)	8. Birthplace (City And State Or Foreign Country)
321-26-3309	75					December 3, 1932	Chicago, IL

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☒ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): William Riley Hospice House

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
Munster, Indiana 46321	Lake	☒ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
Elizabeth Walsh	Molnar	Installer	Communication

18. Residence – State	18a. County	18b. City Or Town	18c. Street And Number	18d. Apt. No.	18e. Zip Code	Inside City Limits?
Indiana	Lake	Highland	3904 Juniper Trail		46322	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
Please select education level: 12	Please select Hispanic origin, if any: No	Please select race: White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
Joseph Walsh	Mary Walsh	Reilly

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
Elizabeth Walsh	Wife	3904 Juniper Trail Highland, IN 46322

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	Heritage Crematory	Portage, Indiana

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	LaHayne Funeral Home 6955 Southeastern Hammond, IN 46320	FH19400005

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Or Licensee):
Edwin B LaHayne	FDO 1000857

Cause Of Death (See Instructions And Examples)

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.

		Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. Metastatic Renal Cell Cancer	
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	Due To (Or As A Consequence Of): B.	
	Due To (Or As A Consequence Of): C.	
	Due To (Or As A Consequence Of): D.	

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Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☐ No ☒ Unknown

32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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?
			☐ Yes ☐ 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: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: Lyle R Munn

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
Lyle Munn, MD 4321 Fir St. East Chicago, IN 46312	0103158 2	3/19/08

46. Additional Funeral Service Provider:	47. *Akas:
Schroeder-Lauer Funeral Home	

48. Signature of Local Health Officer:	49. For Registrar Only – Date Filed (Month/Day/Year):
Susan W Burt D.O.	March 20, 2008

11- CS/ss

State Form 10110 (R7/9-07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7-1-10

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