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2nd

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

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

Local No. 0005-01

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) KENNETH C. SAILORS				2. SEX Male		3a. TIME OF DEATH 7:00PM		3b. DATE OF DEATH (Month Day Yr) September 8, 2001					
4. SOCIAL SECURITY NUMBER 313-07-0090			5a. AGE - Last Birthday (Years) 86		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo Day Yr) September 20, 1914		7. BIRTHPLACE (City and State or Foreign Country) White Cloud, Michigan		
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES 1945		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> (Specify)				9b. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c. CITY TOWN OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) NONE			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor			12b. KIND OF BUSINESS INDUSTRY Steel					
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY TOWN OR LOCATION Hobart			13d. STREET AND NUMBER 8951 Norris Drive						
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 highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+)
18. FATHER'S NAME (First, Middle, Last) Carl Sailors						19. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Fosemore							
20a. INFORMANT'S NAME (Type/Print) Carol Sailors				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8951 Norris Drive, Hobart, IN 46342				20c. Relationship Daughter					
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) September 12, 2001 Chapel Lawn Memorial Gardens				21c. LOCATION (City or Town, State) Schenerville, Indiana					
22a. EMBALMER'S NAME James J. Krause				22b. EMBALMER'S LICENSE NO. FDO1006463		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>				24b. LICENSE NUMBER (of Licensee) FDO1006463		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342							
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>Pulmonary Fibrosis</u> DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions if any which gave rise to the immediate cause stating the underlying cause last										Approximate Interval Between Onset and Death > 3 yrs			
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) 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>[Signature]</i>								29c. MEDICAL LICENSE NO. 01040860		29d. DATE SIGNED (Month Day Year) 9-10-01			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Zlatan Stepanovic MD, 1400 S. Lake Park Avenue, Suite 400, Hobart, IN 46342													
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Best, D.O.</i>										32. DATE FILED (Month Day Year) September 10, 2001			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 SEP 26 2008				
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR						34f. LOCATION (Street and Number or Rural Route Number City or Town State) 016060							
34g. DATE PRONOUNCED DEAD (Month, Day, Year)						34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.							



FILED
SEP 26 2008
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11:00 AM
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