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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to resolve its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS INFORMANT

DISPOSITION

USE OF ATH

CERTIFIER

WITH CER

1 DECEASED—NAME (First, Middle, Last) **JOHN Y. EDDLEMON** 2. SEX **MALE** 3a. TIME OF DEATH **8:00 P.M.** 3b. DATE OF DEATH (Month, Day, Year) **JANUARY 9, 2002**

4. SOCIAL SECURITY NUMBER [REDACTED] 5a. AGE—Last Birthday (Years) **80** 5b. UNDER 1 YEAR Months Days 5c. UNCA 1 DAY Hours Minutes 6. DATE OF BIRTH (Mo, Day, Yr) **Aug. 2, 1921** 7. BIRTHPLACE (City and State or Foreign Country) **Kenton, Tenn.**

8a. WAS DECEASED 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** Inpatient ER/Outpatient DDA **OTHER** Nursing Home Other (Specify) Residence

9b. FACILITY NAME (If not institution, give street and number) **THE COMMUNITY HOSPITAL** 9c. CITY, TOWN, OR LOCATION OF DEATH **MUNSTER** 9d. COUNTY OF DEATH **LAKE**

10. MARITAL STATUS (Specify) **Married** 11. SURVIVING SPOUSE (If wife, give maiden name) **Belva Isom** 12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Shipping Dept** 12b. KIND OF BUSINESS/INDUSTRY **Steel Manufacturing**

13a. RESIDENCE—STATE **Indiana** 13b. COUNTY **Lake** 13c. CITY, TOWN, OR LOCATION **Hammond** 13d. STREET AND NUMBER **1236 177th St.**

13e. ZIP CODE **46324** 13f. INSIDE CITY LIMITS No Yes 13g. ON A FARM? No Yes 14. CITIZEN OF WHAT COUNTRY? **U.S.A.** 15. WAS DECEASED OF HISPANIC ORIGIN? No Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc) 16. RACE—American Indian, Black, White, etc. (Specify) **White** 17. DECEASED'S EDUCATION (Specify only highest grade completed) **12**

18. FATHER'S NAME (First, Middle, Last) **Seth Eddlemon** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **Annie Hundley**

20a. INFORMANT'S NAME (Type/Print) **Belva Eddlemon** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1236 177th St., Hammond, Indiana 46324** 20c. Relationship **Wife**

21a. METHOD OF DISPOSITION Entombment Burial Cremation Removal from State Donation Other (Specify) 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **January 14, 2002 Chapel Lawn Cemetery** 21c. LOCATION—City or Town, State **Schererville, Indiana**

22a. EMBALMER'S NAME: **Edgar C. Gleim** 22b. EMBALMER'S LICENSE NO. **FDO 1016173** 22c. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *Arnold G. Reed* 24b. LICENSE NUMBER (of Licensee) **FDO 1001081** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Kuiper Funeral Home, 9609 Kleinman Rd Highland, Indiana 46322 FH 19900008**

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) **METASTATIC LUNG CANCER**
DUE TO (OR AS A CONSEQUENCE OF):
CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not previously stated in Part I.
PEGOY HOLINGA KATONA LAKE COUNTY AUDITOR

27. WAS DECEASED PREGNANT OR 30 DAYS POSTPARTUM? (Yes or no) No Yes 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No Yes 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No Yes

29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated 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. 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 *Mark Kevin* 29c. MEDICAL LICENSE NO **01036785** 29d. DATE SIGNED (Month, Day, Year) **JANUARY 10, 2002**

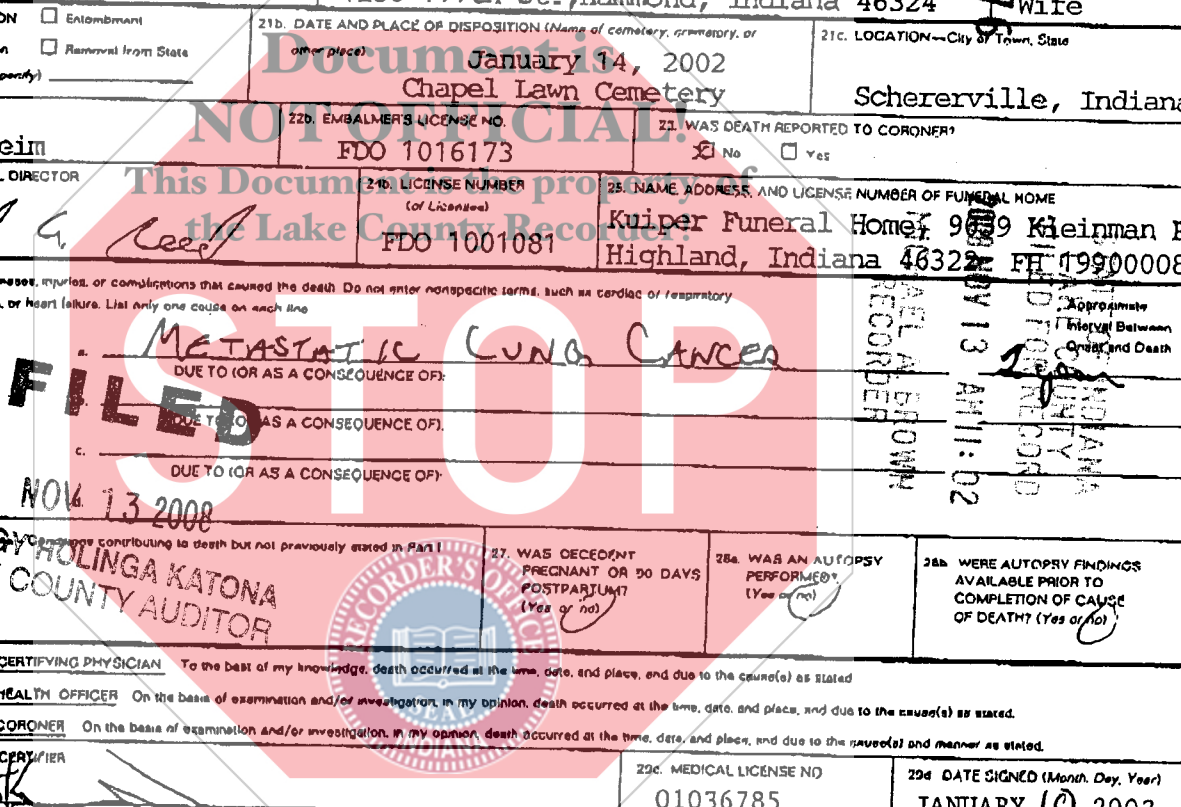
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **MARK KEVIN, M.D., 7905 CALUMET AVENUE MUNSTER, INDIANA 46321**

31. HEALTH OFFICER'S SIGNATURE *Susan J. Best D.O.* 32. DATE FILED (Month, Day, Year) **JANUARY 14, 2002**

33. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide 34a. DATE OF INJURY (Month, Day, Year) 34b. TIME OF INJURY 34c. INJURY AT WORK? (Yes or no) 34d. DESCRIBE HOW INJURY OCCURRED: **\$11 (10) MT**

34e. PLACE OF INJURY—At home (farm, street, factory, office building, etc.) (Specify) 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) **017685**

34g. DATE PRONOUNCED DEAD (Month, Day, Year) 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.



HOLD FOR MERIDIAN TITLE CORP

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