

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

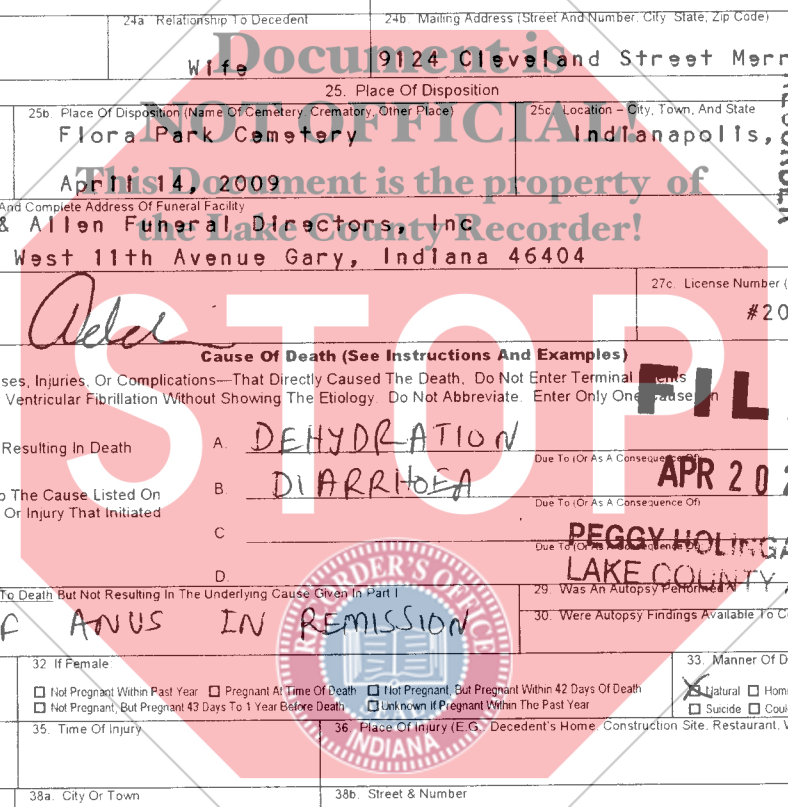


Local No. 1495-09

State No.

Fred H. Mott's Add lot 9 except E 7ft + lot 10 except E 7ft Block 1 45-07-12-233-022.000-004

1 Decedent's Legal Name (First, Middle, Last) James L. Pence				1a Maiden Last Name (If Female) N/A		2 Sex Male	3 Time Of Death 5:13 AM	4 Date Of Death (Month/Day/Year) April 5, 2009			
5 Social Security Number 406-22-8216		6a Age - Yrs 82	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) March 6, 1927		8 Birthplace (City And State Or Foreign Country) Louisville, Kentucky		
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) Methodist Hospital Southlake											
12 City Or Town, State, And Zip Code Merrillville, Indiana					13 County Of Death Lake			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 Vergie M. Pence			15a (If Wife) Give Maiden Last Name O'Neal		16 Decedent's Usual Occupation Mail Handler			17 Kind Of Business/Industry U S Postal Service			
18 Residence - State Indiana			18a County Lake		18b City Or Town Merrillville						
18c Street And Number 9124 Cleveland Street					18d Apt No.		18e Zip Code 46410	18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
19 Decedent's Education 9th Grade			20 Decedent Of Hispanic Origin NO		21 Decedent's Race Black						
22 Father's Name (First, Middle, Last) Robert M. Pence				23 Mother's Name (First, Middle, Last) Mamie B. Pence			23a Mother's Maiden Last Name Scott				
24 Informant's Name Vergie M. Pence			24a Relationship To Decedent Wife		24b Mailing Address (Street And Number, City, State, Zip Code) 9124 Cleveland Street Merrillville, Indiana 46410						
25a Method Of Disposition <input checked="" type="checkbox"/> Burial <input 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) Flora Park Cemetery		25c Location - City, Town, And State Indianapolis, Indiana		25d Date Of Disposition April 14, 2009					
26 Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27 Name And Complete Address Of Funeral Facility Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404					27a License Number 0007704				
27b Signature Of Indiana Funeral Service Licensee <i>Maureen Adair</i>					27c License Number (Of Licensee) #20500009						
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. DEHYDRATION B. DIARRHOEA C. _____ D. _____ 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 CARCINOMA OF ANUS IN REMISSION											
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 Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The 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)			37 Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) 002913					
41 Signature, Of Person Certifying Cause Of Death <i>Dr. B. Barai</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 200 E 89th Ave Ste 2A Merrillville IN 46410							44 License Number 01036107A	45 Date Certified 4-6-09			
46 Additional Funeral Service Provider:							47 *Akas: 1100 CASH PB				
48 Signature of Local Health Officer: <i>Susan W Best DO</i>						49 For Registrar Only - Date Filed (Month/Day/Year) April 13, 2009					



2009 APR 20 11:00 AM
MICHAEL A. BROWN
RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
0007704