



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

EXHIBIT A

Local No. 1480-09

State No. _____

1 Decedent's Legal Name (First, Middle, Last) Patricia Ann Norton				1a Maiden Last Name (If Female) Smith		2 Sex Female	3 Time Of Death 9:56 a.m.	4 Date Of Death (Month/Day/Year) April 7, 2009		
5 Social Security Number 303-34-7504	6a Age - Yrs 74	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) Aug. 17, 1934		8 Birthplace (City And State Or Foreign Country) Owen County, Indiana		
9 Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10 If Death Occurred In A Hospital <input 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 checked="" 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) 1254 Fisher Street										
12 City Or Town, State, And Zip Code Munster, Indiana 46321					13 County Of Death Lake		14 Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15 Surviving Spouse's Name None			15a (If Wife) Give Maiden Last Name -		16 Decedent's Usual Occupation School Teacher		17 Kind Of Business/Industry Elementary School			
18 Residence - State Indiana		18a County Lake			18b City Or Town Munster		18d Apt No -	18e Zip Code 46321	18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19 Decedent's Education Master's Degree			20 Decedent Of Hispanic Origin No		21 Decedent's Race White					
22 Father's Name (First, Middle, Last) Roy Allen Smith			23 Mother's Name (First, Middle, Last) Marjorie Smith			23a Mother's Maiden Last Name Bennett				
24 Informant's Name Susan C. Norton		24a Relationship To Decedent Daughter			24b Mailing Address (Street And Number, City, State, Zip Code) 6916 Carmel Ridge Road, Morgantown, IN 46160					
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) April 11, 2009 Marshall Cemetery			25c Location - City, Town, And State Marshall, Illinois					
26 Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27 Name And Complete Address Of Funeral Facility Anthony & Dziadowicz Funeral Home			27a Funeral Home License Number: 83002916		27b Signature Of Indiana Funeral Service Licensee <i>Anthony J. Dziadowicz</i>			
					27c License Number (Of Licensee): 01001447					
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. Advanced Metastatic Breast Cancer										
B. Obstructive Pulmonary Disease										
C. _____										
D. _____										
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I Type II Diabetes Colon Cancer					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 checked="" 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			37 Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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)			38 Zip Code			
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)			
41 Signature Of Person Certifying Cause Of Death <i>Paul L. Good M.D.</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 9600 Wicker Ave St. John, IN 46373					44 License Number 01027057A		45 Date Certified 4/7/09			
46 Additional Funeral Service Provider					47 *Akas					
48 Signature of Local Health Officer <i>Susan W. Best, D.O.</i>					49 For Registrar Only - Date Filed (Month/Day/Year) April 8, 2009					