

STATE OF MICHIGAN
COUNTY OF ALLEGAN
ALLEGAN, MICHIGAN



I, Joyce A. Watts Clerk of Allegan County, and Clerk of the Circuit Court for said County, the same being a Court of Record, having a seal, do hereby certify that this a true copy of the record now remaining in my office, and the whole thereof.

IN TESTIMONY WHEREOF: I have hereunto set my hand and official

seal this 18th day of April A.D. 2005

Joyce A. Watts Clerk

By Cuelyn Timmer Deputy Clerk

2010 004175

TYPE/PRINT
IN
PERMANENT
BLACK INK

LF _____
CF 2005-251
10ccf



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER
2469862

NAME OF DECEDENT
For use by physician or institution

PARENTS

INFORMANT

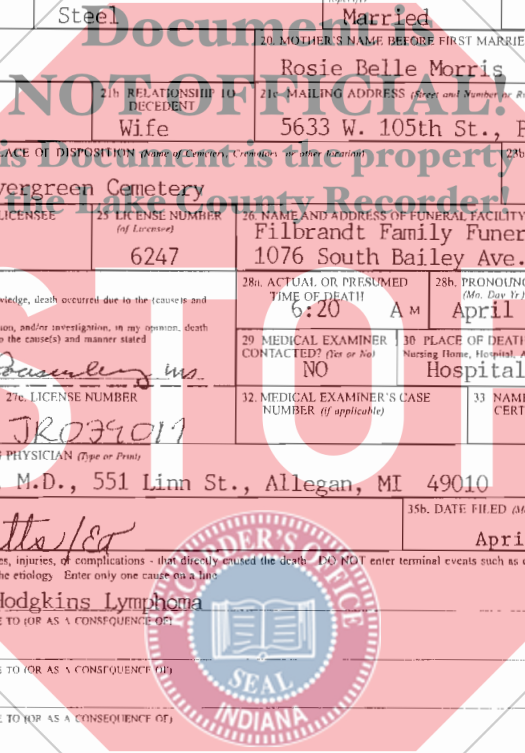
DISPOSITION

CERTIFICATION

CAUSE OF DEATH

MEDICAL EXAMINER

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOE LEE MABONE | | 2. DATE OF BIRTH (Month, Day, Year) May 11, 1924 | | 3. SEX Male | | 4. DATE OF DEATH (Month, Day, Year) April 10, 2005 | |
| 5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS (Lastname, Initials, etc.) | | | | 6a. AGE - Last Birthday (Years) 80 | | 6b. UNDER 1 YEAR MONTHS: _____ DAYS: _____ | |
| 6c. UNDER 1 DAY HOURS: _____ MINUTES: _____ | | | | 7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH Allegan City | | 7c. COUNTY OF DEATH Allegan | |
| 7a. LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) Allegan General Hospital | | 8a. CURRENT RESIDENCE - STATE Michigan | | 8b. COUNTY Allegan | | 8c. LOCALITY (check the box that describes the location) <input type="checkbox"/> CITY OR VILLAGE (outside limits of) <input checked="" type="checkbox"/> TOWNSHIP <input type="checkbox"/> UNINCORPORATED PLACE Lee | |
| 8d. STREET AND NUMBER (Include apt. No. if applicable) 5633 W. 105th St. | | 9. BIRTHPLACE (City and State or Country) Collierville, Tennessee | | 10. SOCIAL SECURITY NUMBER 409-32-9969 | | 11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death? 8th Grade | |
| 12. RACE - American Indian, White, Black, etc. (If Asian, give nationality or Chinese, Filipino, Asian Indian, etc.) (Enter all that apply) Black | | 13a. ANCESTRY Mexican, Cuban, Arab, African, English, French, Dutch, etc. (Enter all that apply) If American Indian race, enter principal tribe African American | | 13b. HISPANIC ORIGIN (Yes or No) No | | 14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES (Yes or No) No | |
| 15. USUAL OCCUPATION Give kind of work done during most of working life. Do not use retired. Laborer | | 16. KIND OF BUSINESS OR INDUSTRY Steel | | 17. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married | | 18. NAME OF SURVIVING SPOUSE (If deceased, give name before first married) Maggie J. Saul | |
| 19. FATHER'S NAME (First, Middle, Last) Joel Mabone | | | | 20. MOTHER'S NAME BEFORE FIRST MARRIED (First, Middle, Last) Rosie Belle Morris | | | |
| 21a. INFORMANT'S NAME (Type/Print) Maggie J. Mabone | | 21b. RELATIONSHIP TO DECEDENT Wife | | 21c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, Zip Code) 5633 W. 105th St., Pullman, MI 49450 | | | |
| 22. METHOD OF DISPOSITION Burial | | 23. PLACE OF DISPOSITION (Name of Cemetery, Crematorium, or other Institution) Evergreen Cemetery | | 24. LOCATION - City or Village, State Gary, Indiana | | | |
| 24. SIGNATURE OF MORTUARY SCIENCE LICENSEE <i>[Signature]</i> | | 25. LICENSE NUMBER (of Licensee) 6247 | | 26. NAME AND ADDRESS OF FUNERAL FACILITY Filbrandt Family Funeral Home 1076 South Bailey Ave., South Haven, MI 49090 | | | |
| 27a. CERTIFIER (check only one) <input checked="" type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the (causes and manner stated) | | 28a. ACTUAL OR PRESUMED TIME OF DEATH 6:20 A.M. | | 28b. PRONOUNCED DEAD ON (Mo, Day, Yr) April 10, 2005 | | 28c. TIME PRONOUNCED DEAD 6:20 A.M. | |
| <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the causes and manner stated | | 29. MEDICAL EXAMINER CONTACTED? (Yes or No) NO | | 30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) (Specify) Hospital | | 31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, DDA (Specify) Inpatient | |
| 27b. DATE SIGNED (Mo, Day, Yr) April 15, 2005 | | 27c. LICENSE NUMBER IJR039017 | | 32. MEDICAL EXAMINER'S CASE NUMBER (if applicable) | | 33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) | |
| 34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN (Type or Print) John M. Roosenberg, M.D., 551 Linn St., Allegan, MI 49010 | | | | 35. REGISTRAR'S SIGNATURE <i>Joyce A. Watts</i> | | | |
| 35a. REGISTRAR'S SIGNATURE | | | | 35b. DATE FILED (Month, Day, Year) April 18, 2005 | | | |
| 36. 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 cardiac fibrillation without showing the etiology. Enter only one cause on a line. If diabetes was an immediate, underlying or contributory cause of death be sure to record diabetes in either Part I or Part II of the cause of death section, as appropriate | | | | | | | Approximate Interval Between Onset and Death 5 years |
| a. Non-Hodgkins Lymphoma DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | |
| b. _____ DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | |
| c. _____ DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | |
| d. _____ DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | |
| 37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 38. IF FEMALE: <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 1 to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year | | | | | | | |
| 39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate or Pending (Specify) Natural | | 40a. WAS AN AUTOPSY PERFORMED? (Yes or No) No | | 40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) | | | |
| 41a. DATE OF INJURY (Mo, Day, Yr) | | 41b. TIME OF INJURY M | | 41c. DESCRIBE HOW INJURY OCCURRED PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR | | | |
| 41d. INJURY AT WORK (Yes or No) | | 41e. PLACE OF INJURY - At home, farm, street, construction site, wooded area, etc. (Specify) | | 41f. IF TRANSPORTATION INJURY - Driver/Operator, Passenger, Pedestrian, etc. (Specify) | | | |
| 41g. LOCATION - Street or RFD No. | | 050429 State | | | | | |



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