



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

DSM AUG 07 2008

Local No. *112-01*

45-12-17-305-004,000

State No. *12-30*

1. Decedent's Legal Name (First, Middle, Last) THOMAS JOHN MACHIN		1a. Maiden Last Name (If Female)		2. Sex M	3. Time Of Death 4:02 AM	4. Date Of Death (Month/Day/Year) JANUARY 21, 2008	
5. Social Security Number 308-32-1911	6a. Age - Yrs 75	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) November 28, 1932	8. Birthplace (City and State Or Foreign Country) ERIE, PENNSYLVANIA
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 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 checked="" 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) ST. ANTHONY IN-PATIENT HOSPICE 203 FRANCISCAN DRIVE							
12. City Or Town, State, And Zip Code CROWN POINT, INDIANA 46307				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 NANCY MACHIN		15a. (If Wife) Give Maiden Last Name GERECY		16. Decedent's Usual Occupation LABORER		17. Kind Of Business/Industry US STEEL	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town MERRILLVILLE		18c. Zip Code 46410	
18c. Street And Number 2963 W. 74TH AVENUE		18d. Apt. No.		18e. Zip Code 46410		18f. Outside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
19. Decedent's Education High school graduate or GED completed		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino		21. Decedent's Race White			
22. Father's Name (First, Middle, Last) RAY MACHIN		23. Mother's Name (First, Middle, Last) MARIAN MACHIN		23a. Mother's Maiden Last Name BOYD			
24. Informant's Name NANCY MACHIN		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 2963 W. 74TH AVENUE MERRILLVILLE, IN. 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) CHapel LAWN MEMORIAL GARDENS		25c. Location - City, Town, And State SCHERERVILLE, INDIANA			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility GEISEN FUNERAL HOME, INC 7905 BROADWAY, MERRILLVILLE, INDIANA 46410				27a. Funeral Home License Number: FH83007762	
27b. Signature Of Indiana Funeral Service Licensee <i>Alexis Thomas</i>				27c. License Number (Of Licensee) FDO8600505			
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. LUNG CANCER Due To (Or As A Consequence Of) B. _____ Due To (Or As A Consequence Of) C. _____ Due To (Or As A Consequence Of) 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							
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I							
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input 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. Residence, Home, Construction Site, Restaurant, Wooded Area)		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" 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)			
41. Signature, Of Person Certifying Cause Of Death: <i>R S Drasga</i>				42. Certifier (Check Only One) <input 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: Ray E. Drasga, M.D., 1205 S. Main St. Suite 301, Crown Point, IN 46307				44. License Number 01031989		45. Date Certified 01/23/2008	
46. Additional Funeral Service Provider:				47. *Akas: 000328			
48. Signature of Local Health Officer: <i>Susan W But. D.O.</i>				49. For Registrar Only - Date Filed (Month/Day/Year) <i>January 23, 2008</i>			

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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR