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

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 3803-05

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER I.C. 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED NAME (First, Middle, Last) Carl Brown		2. SEX Male	3a. TIME OF DEATH 5:35 P M	3b. DATE OF DEATH (Month, Day, Yr) November 01, 2005
4. SOCIAL SECURITY NUMBER 317-38-4572		5a. AGE - Last birthday (Years) 61	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo, Day, Yr) October 28, 1944		7. BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana		
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		9. PLACE OF DEATH (Check only one. See Instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DCA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Nursing Home
10. FACILITY NAME (If not institution, give street and number) 9110 Tapper Street		11. CITY, TOWN, OR LOCATION OF DEATH St. John		12. COUNTY OF DEATH Lake
13. MARRITAL STATUS (Specify) Married		14. SURVIVING SPOUSE (If wife, give maiden name) Jinda Raper		15. DECEASED'S USUAL OCCUPATION (Give title of work done during most of working life. Do not use retired) Pipefitter
16. RESIDENCE - STATE Indiana		17. COUNTY Lake		18. CITY, TOWN, OR LOCATION St. John
19a. ZIP CODE 46373		19b. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		19c. STREET AND NUMBER 9110 Tapper Street
20. CITIZENSHIP USA		21. YEAR DECEDENT OF HISPANIC ORIGIN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		22. RACE - American Indian, Black, White, etc. (Specify) White
23. EDUCATION (Specify only highest grade completed) 12		24. DECEASED'S EDUCATION (Specify only highest grade completed) College (1-4 of 5)		
25. FATHER'S NAME (First, Middle, Last) Howard Brown		26. MOTHER'S NAME (First, Middle, Maiden Surname) Jean Podkul		
27. INFORMANT'S NAME (Typed/print) Linda Brown		28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9110 Tapper Street St. John, Indiana 46373		29. Relationship Wife
30. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Other (Specify)		31. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 07, 2005 Oakland Memory Lawn		32. LOCATION - City or Town, State Dolton, Illinois
33. EMBALMER'S NAME Steven J. Struck		34. EMBALMER'S LICENSE NO. FD08600181		35. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
36. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		37. LICENSE NUMBER OF LICENSEE FD20500007		38. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Chapel Lawn Funeral Home, FH19900051 8178 Cline Avenue, Schererville, Indiana, 46375
39. PART I. IMMEDIATE CAUSE (Final disease or condition resulting in death) RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF) METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF)		39. PART II. Other significant conditions - Conditions contributing to death but not directly stated in Part I.		
40. CERTIFIER (Check only one) <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		41. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 39 (Typed/print) MARK ABCZINSKI, D.O. 9495 KEILMAN ST ST JOHN IN 46		43. MEDICAL LICENSE NO. 02001056		44. DATE SIGNED (Month, Day, Year) 11-04-2005
45. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		46. DATE FILED (Month, Day, Year) November 8, 2005		
47. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Perinatal Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		48. DATE OF INJURY (Month, Day, Year)		49. TIME OF INJURY
50. PLACE OF INJURY (At home, hotel, street, prison, office, business, etc. (Specify))		51. LOCATION (Street and Number or Rural Route Number, City or Town, State) Filed in Clerk's Office JUN 15 2006		
52. DATE PRONOUNCED DEAD (Month, Day, Year)		53. MOTOR VEHICLE ACCIDENT (Yes or No) If yes, specify driver, passenger, pedestrian, etc. Thomas R. Philpot CLERK LAKE CIRCUIT COURT		