ATTENTION ESTATE: Disclosure of the S# we need to pursue our responsibilities voluntary and there will be no penalty for refusal.*

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2879-94 State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Leve Knight
2. SEX	Male
3a. TIME OF DEATH	5:47P M
3b. DATE OF DEATH (Month, Day, Yr)	November 4, 1994
4. *SOCIAL SECURITY NUMBER	402-18-5646
5a. AGE—Last Birthday (Years)	87
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	March 6, 1907
7. BIRTHPLACE (City and State or Foreign Country)	Crabtree, Kentucky
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	
9a. PLACE OF DEATH (Check only one. See Instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	St. Anthony Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	Crown Point
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Frocie Chadwick
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Laborer
12b. KIND OF BUSINESS/INDUSTRY	Construction
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Cedar Lake
13d. STREET AND NUMBER	8711 West 131st Street
13e. ZIP CODE	46303
13f. INSIDE CITY LIMITS?	☒ No ☐ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	2

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Cliff Knight
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Elley MacAnay

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Frocie Knight
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8711 West 131st Street Cedar Lake, Indiana 46303
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	November 7, 1994 Memory Lane Cemetery
21c. LOCATION—City or Town, State	Schererville, Indiana
22a. EMBALMER'S NAME	Fred Ozarka
22b. EMBALMER'S LICENSE NO.	FD01016076
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Fred Ozarka
24b. LICENSE NUMBER (of Licensee)	FD01016076
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Eller Brady Funeral Home, Inc. FH83000825 Cedar Lake, Indiana 46303

CAUSE OF DEATH

26. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Cerebrovascular accident

b. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cerebrovascular disease

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF): Hypertension

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Degenerative arthritis

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	No

CERTIFIER

29a. CERTIFIER (Check only one)
- ☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
- ☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated.
- ☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	IN 25043
29d. DATE SIGNED (Month, Day, Year)	11/8/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Krishnan Potti 8300 Broadway Merrillville, Indiana

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander [signature]
32. DATE FILED (Month, Day, Year)	November 9, 1994

FILED

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)	
34b. TIME OF INJURY	
34c. INJURY AT WORK? (Yes or no)	
34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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2011 026 May
2011 026847
052751 MAY 12 2011
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

*This document is being recorded to add Auditor stamp. RJ
COMMUNITY TITLE COMPANY
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