

STATE OF MICHIGAN )  
COUNTY OF BERRIEN ) SS

I, M. LOUISE STINE, Clerk of the County of Berrien, Clerk of the Circuit Court of said County, the same being a Court of Record and having a seal, do hereby certify

that I have compared the below copy with the record thereof now remaining in my office and have found it to be a true copy.

IN TESTIMONY WHEREOF, I have hereunto set my hand and have affixed the Seal of said Circuit Court at St. Joseph, this 29th day of June, A.D. 2010.

M. LOUISE STINE  
COUNTY CLERK

*Peggy Olaus*  
DEPUTY CLERK

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#45-09-21-330-001.000-045

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STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
CERTIFICATE OF DEATH

STATE FILE NUMBER  
3303573

NAME OF DECEDENT  
For use by physician or institution  
CHICAGO TITLE INSURANCE COMPANY

1. DECEDENT'S NAME (First, Middle, Last) <b>Harold Norman Stangebye</b>		2. DATE OF BIRTH (Month, Day, Year) July 10, 1917		3. SEX Male		4. DATE OF DEATH (Month, Day, Year) June 23, 2010	
5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS (Include AKA's if any)				6a. AGE - Last Birthday (Years) 92		6b. UNDER 1 YEAR MONTHS 6c. UNDER 1 DAY HOURS MINUTES	
7a. LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) HOSPITAL OR OTHER INSTITUTION - Name (if not in either, give street and number and zip code) West Woods of Niles				7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH Niles Charter Township		7c. COUNTY OF DEATH Berrien	
8a. CURRENT RESIDENCE - STATE Michigan		8b. COUNTY Berrien		8c. LOCALITY (check the box that describes the location) <input type="checkbox"/> CITY OR VILLAGE (inside limits of) <input checked="" type="checkbox"/> TOWNSHIP <input type="checkbox"/> UNINCORPORATED PLACE Niles		8d. STREET AND NUMBER (Include Apt. No. if applicable) 1211 State Line Road	
8e. ZIP CODE 49120		9. BIRTHPLACE (City and State or Country) Chicago, Illinois		10. SOCIAL SECURITY NUMBER <del>000000</del> 8918		11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death? Two Years College	
12. RACE - American Indian, White, Black, etc. (If Asian, give nationality, ie. Chinese, Filipino, Asian Indian, etc.) (Enter all that apply) White		13a. ANCESTRY - Mexican, Cuban, Arab, African, English, French, Dutch, etc. (Enter all that apply) If American Indian race, enter principal tribe American		13b. HISPANIC ORIGIN (Yes or No) No		14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES? (yes or no) Yes	
15. USUAL OCCUPATION Give kind of work done during most of working life. Do not use retired. Welder-Repair Man		16. KIND OF BUSINESS OR INDUSTRY Steel		17. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed		18. NAME OF SURVIVING SPOUSE (if wife, give name before first married)	
19. FATHER'S NAME (First, Middle, Last) Harold Stangebye				20. MOTHER'S NAME BEFORE FIRST MARRIED (First, Middle, Last) Olga Olson			
21a. INFORMANT'S NAME (Type/Print) Cynthia Razo		21b. RELATIONSHIP TO DECEDENT Daughter		21c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, Zip Code) 6019 Meadowlark, Portage, Indiana 46368			
22. METHOD OF DISPOSITION Burial		23a. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other location) Calvary Cemetery				23b. LOCATION - City or Village, State Portage, Indiana	
24. SIGNATURE OF MORTUARY SCIENCE LICENSEE <i>John Bobbitt III</i>		25. LICENSE NUMBER (of Licensee) 5181		26. NAME AND ADDRESS OF FUNERAL FACILITY Rees Funeral Home 600 West Old Ridge, P.O. Box 488, Hobart, Indiana 46342			
27a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the (cause) and manner stated. <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 cause(s) and manner stated.				28a. ACTUAL OR PRESUMED TIME OF DEATH 8:49 P M		28b. PRONOUNCED DEAD ON (Mo, Day, Yr.) June 23, 2010	
Signature and Title <i>Alphonso Berry M.D.</i>		29. MEDICAL EXAMINER CONTACTED? (Yes or No) No		30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) (Specify) Nursing Home		31. HOSPITAL, Inpatient, Outpatient, Emergency Room, DOA (Specify)	
27b. DATE SIGNED (Mo, Day, Yr.) June 25, 2010		27c. LICENSE NUMBER 053422		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) Alphonso Berry M.D., 23550 Haggerty, Farmington Hills, Michigan 48335							
35a. REGISTRAR'S SIGNATURE <i>M. Louise Stine</i>				35b. DATE FILED (Month, Day, Year) June 29, 2010			

CAUSE OF DEATH

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 ventricular fibrillation without showing the etiology. Enter only one cause on a line. If diabetes was an immediate, underlying or contributing cause of death be sure to record diabetes in either Part I or Part II of the cause of death section, as appropriate. IMMEDIATE CAUSE (Final disease or condition resulting in death) 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		Approximate Interval Between Onset and Death	
a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF)		Few minutes	
b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF)		Unknown	
c. Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF)		Unknown	
d. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF)		Unknown	

PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I.

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 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"/> Pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	
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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) <b>FILED</b>	
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IVa  
MEDICAL EXAMINER

41a. DATE OF INJURY (Mo., Day, Yr.)		41b. TIME OF INJURY M		41c. DESCRIBE HOW INJURY OCCURRED <b>054979</b>	
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.		City, Village or Twp. PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		State	

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