



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No 002483

EDR No 00000214425

State No

1. Decedent's Legal Name (First, Middle, Last) <b>NORMA L SARK</b>				1a. Maiden Name (If female) <b>WORLEY</b>		2. Sex <b>FEMALE</b>	3. Time Of Death <b>03:00 PM</b>	4. Date Of Death (Month/Day/Year) <b>08/11/2011</b>	
5. Social Security Number <b>315-28-6184</b>	6a. Age - Yrs <b>82</b>	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) <b>08/17/1928</b>		8. Birthplace (City and State or Foreign Country) <b>LOWELL, IN</b>	
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Hospice Facility <input checked="" 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) <b>1688 PINERIDGE CIRCLE</b>									
12. City Or Town, State, And Zip Code <b>LOWELL, IN, 46356</b>					13. County Of Death <b>LAKE</b>		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 <b>CLYDE SARK</b>			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation <b>BOOKKEEPER</b>		17. Kind Of Business/Industry <b>FARM EQUIPMENT SALES</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>LOWELL</b>		18c. Street And Number <b>1688 PINERIDGE CIRCLE</b>		18d. Apt. No.	18e. Zip Code <b>46356</b>
18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>		20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>White</b>			
22. Father's Name (First, Middle, Last) <b>ELMER WORLEY</b>				23. Mother's Name (First, Middle, Last) <b>BLANCHE WORLEY</b>		23a. Mother's Maiden Last Name <b>RUBLE</b>			
24. Informant's Name <b>CLYDE SARK</b>			24a. Relationship To Decedent <b>SPOUSE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>1688 PINERIDGE CIRCLE, LOWELL, IN 46356</b>				
25. Place Of Disposition									
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) <b>LOWELL MEMORIAL CEMETERY</b>			25c. Location - City, Town, And State <b>LOWELL, IN</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>SHEETS FUNERAL HOME AND CREMATION SERVICES, 604 E. COMMERCIAL AVENUE, LOWELL, IN 46356</b>					27a. Funeral Home License Number: <b>7810004277</b>		
27b. Signature Of Indiana Funeral Service Licensee: <b>KEN P. SHEETS, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>08900045</b>			
28. Part I. Enter The <u>Chain Of Events</u> - 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. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> Due to (Or As A Consequence Of)									
B. <u>ACUTE BACTERIAL PNEUMONIA</u> Due to (Or As A Consequence Of)									
C. <u>ACUTE ATRIAL FIBRILLATION</u> Due to (Or As A Consequence Of)									
D. <u>DIASTOLIC HEART FAILURE FROM HYPERTENSION</u> Due to (Or As A Consequence Of)									
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I									
GRAVES THYROIDITIS, HYPERTENSION									
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" 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., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input 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: <b>RANDALL LEE HILE, BY ELECTRONIC SIGNATURE</b>									
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>RANDALL LEE HILE, 1020 COMMERCIAL AVE, LOWELL, IN 46356</b>									
46. Additional Funeral Service Provider:						44. License Number <b>01030234A</b>		45. Date Certified <b>08/16/2011</b>	
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						47. *Akas. <b>\$ 11</b>			
49. For Registrar Only - Date Filed (Month/Day/Year): <b>AUG 17 2011</b>						AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)			
Parcel # 45-19.24-330-040.000-008 028589 CA									

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.