



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

I HEREBY CERTIFY THIS TO BE A TRUE
AND EXACT COPY OF THE ORIGINAL.

Local No 002389

EDR No 00000211510

State No 034414

1. Decedent's Legal Name (First, Middle, Last) GEORGE W CARLSON				1a. Maiden Name (If female)		2. Sex MALE		3. Time Of Death 08:25 AM		4. Date Of Death (Month/Day/Year) 07/29/2011		
5. Social Security Number 306-01-7730		6a. Age - Yrs 98		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) 01/06/1913		8. Birthplace (City and State or Foreign Country) CHICAGO, IL										
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 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) WILLIAM J. RILEY MEMORIAL RESIDENCE, HOSPICE												
12. City Or Town, State, And Zip Code MUNSTER, IN, 46321						13. County Of Death LAKE			14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name				15a. (If Wife) Give Maiden Last Name				16. Decedent's Usual Occupation CITY COUNCILMAN		17. Kind Of Business/Industry CITY OF HAMMOND		
18. Residence - State INDIANA			18a. County LAKE			18b. City Or Town HAMMOND			18c. Street And Number 7343 ARIZONA AVENUE		18d. Apt. No.	
18e. Zip Code 46323			18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White			
22. Father's Name (First, Middle, Last) GEORGE E. CARLSON				23. Mother's Name (First, Middle, Last) MARY CARLSON				23a. Mother's Maiden Last Name BOUGHEY				
24. Informant's Name DOUGLAS G CARLSON				24a. Relationship To Decedent SON				24b. Mailing Address (Street And Number, City, State, Zip Code) 7343 ARIZONA AVENUE, HAMMOND, IN 46323				
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) RIDGELAWN CEMETERY			25c. Location - City, Town, And State GARY, IN						
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility BURNS-KISH FUNERAL HOME INC-MUNSTER, 8415 CALUMET AVE, MUNSTER, IN 46321						27a. Funeral Home License Number: FH83004988				
27b. Signature Of Indiana Funeral Service Licensee: BRIAN T. BURNS, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee): FD08601763						
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. HYPERTENSION Due to (Or As A Consequence Of):												
B. DEGENERATIVE JOINT DISEASE Due to (Or As A Consequence Of):												
C. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (Or As A Consequence Of):												
D. ANXIETY 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												
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 type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" 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			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: M. ASEF RAHMANY, BY ELECTRONIC SIGNATURE												
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: M. ASEF RAHMANY, 2914 HIGHWAY AVE, HIGHLAND, IN 46322						44. License Number 01026043A		45. Date Certified 08/09/2011				
46. Additional Funeral Service Provider: PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR												
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE												
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) AUG 09 2011												
MERIDIAN TITLE CORPORATION HAS MADE AN ACCOMODATION RECORDING OF THIS DOCUMENT 028794												

11.00
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