



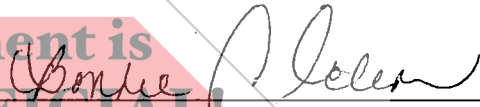
Subscribed and sworn to before me, a Notary Public, this 14<sup>th</sup> day of January, 2014.



Bonnie C. Coleman, Notary Public  
A Resident of Porter County

My Commission Expires:  
September 19, 2016

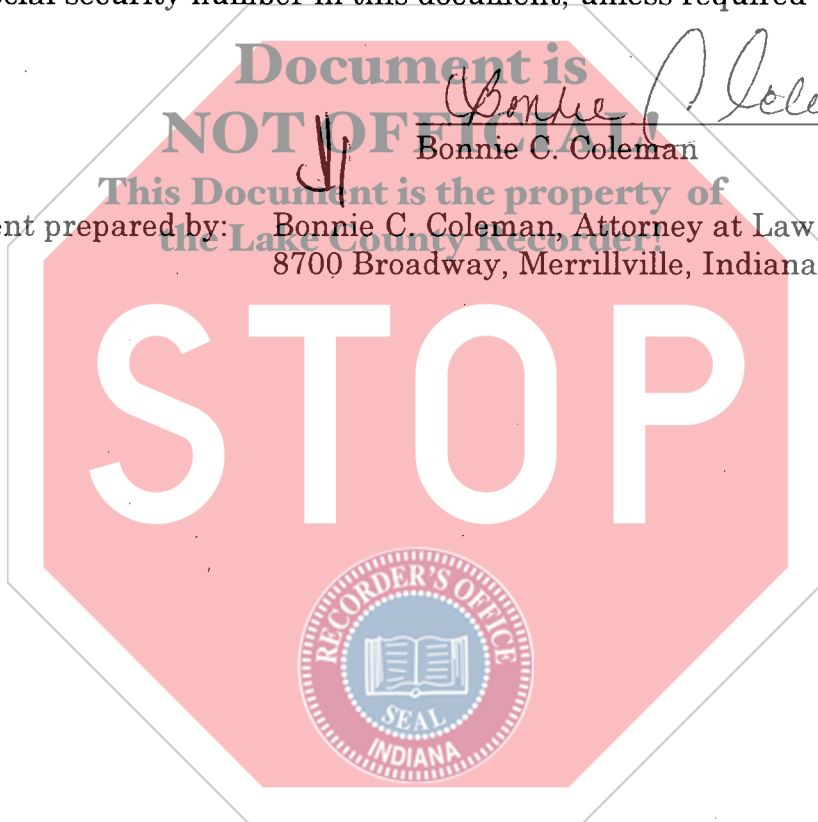
I affirm, under the penalties for perjury, that I have taken reasonable care to redact each social security number in this document, unless required by law.



Bonnie C. Coleman

This instrument prepared by: Bonnie C. Coleman, Attorney at Law  
8700 Broadway, Merrillville, Indiana 46410

219744.1  
16,519





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tracking No. 01023

Local No 003716

EDR No 000000353242

State No 052141

1. Decedent's Legal Name (First, Middle, Last) <b>BENJAMIN T LUNA</b>				1a. Maiden Name (If female)		2. Sex <b>MALE</b>		3. Time Of Death <b>01:15 AM</b>		4. Date Of Death (Month/Day/Year) <b>11/13/2013</b>		
5. Social Security Number		6a. Age - Yrs <b>76</b>		6b. Under 1 Year		6c. Under 1 Month		6d. Under 1 Day		6e. Under 1 Hour		
		Months		Days		Hours		Minutes		7. Date of Birth (Month/Day/Year) <b>09/04/1937</b>		
										8. Birthplace (City and State or Foreign Country) <b>GARY, 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>6280 WAXWING CIRCLE</b>												
12. City Or Town, State, And Zip Code <b>HOBART, IN, 46342</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>CAROLYN LUNA</b>				15a. (If Wife) Give Maiden Last Name <b>LOPEZ</b>				16. Decedent's Usual Occupation <b>PRINCIPAL</b>		17. Kind Of Business/Industry <b>EDUCATION</b>		
18. Residence - State <b>INDIANA</b>			18a. County <b>LAKE</b>			18b. City Or Town <b>HOBART</b>			18d. Apt. No.		18e. Zip Code <b>46342</b>	
18c. Street And Number <b>6280 WAXWING CIRCLE</b>												
18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
19. Decedent's Education <b>MASTER'S DEGREE (MA, MS, MENG, MED, MSW, MBA)</b>				20. Decedent Of Hispanic Origin <b>HISPANIC</b>				21. Decedent's Race <b>White</b>				
22. Father's Name (First, Middle, Last) <b>INES LUNA</b>				23. Mother's Name (First, Middle, Last) <b>FLAVIA LUNA</b>				23a. Mother's Maiden Last Name <b>ESKINEL</b>				
24. Informant's Name <b>CAROLYN LUNA</b>				24a. Relationship To Decedent <b>WIFE</b>				24b. Mailing Address (Street And Number, City, State, Zip Code) <b>6280 WAXWING CIRCLE, HOBART, IN 46342</b>				
25. Place Of Disposition												
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment			25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>KELLY CARROLL CREMATION SERVICES</b>			25c. Location - City, Town, And State <b>GARY, IN</b>						
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			27. Name And Complete Address Of Funeral Facility <b>REES FUNERAL HOME, HOBART CHAPEL, 600 W OLD RIDGE RD, HOBART, IN 46342</b>				27a. Funeral Home License Number <b>FH83003069</b>					
27b. Signature Of Indiana Funeral Service Licensee: <b>JAMES J. KRAUSE, BY ELECTRONIC SIGNATURE</b>										27c. License Number (Of Licensee): <b>FD01006463</b>		
Cause Of Death (See Instructions And Examples)												
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. <b>MALIGNANT NEOPLASM OF PANCREAS WITH DIABETES MELLITUS, WEIGHT LOSS, AND WITH THE SARCOPENIA</b>												
Due to (Or As A Consequence Of):												
B. <b>PARKINSONS DISEASE WITH DYSPHAGIA AND DEMENTIA</b>												
Due to (Or As A Consequence Of):												
C. _____												
Due to (Or As A Consequence Of):												
D. _____												
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												
SIGMOID VOLVULUS SURGICALLY CORRECTED YEARS AGO												
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" 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) <b>NOT VALID UNLESS</b>						
41. Signature Of Person Certifying Cause Of Death: <b>MICHAEL CARL WEISS, BY ELECTRONIC SIGNATURE</b>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer						
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>MICHAEL CARL WEISS, 2404 VALPARAISO STREET, VALPARAISO, IN 46383</b>						44. License Number <b>01030965A</b>		45. Date Certified <b>11/14/2013</b>				
46. Additional Funeral Service Provider:						47. *Akas:						
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>NOV 15 2013</b>						

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)