

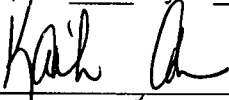


STATE OF Indiana )  
 ) SS:  
COUNTY OF Lake )

Before me, a Notary Public in and for said County and State, personally appeared ALAN A. MANNS, who acknowledged the execution of the foregoing Affidavit and acknowledged his execution of it as his voluntary act and deed for the uses and purposes stated in it.

WITNESS my hand and Notarial Seal, this 23rd day of October, 2013.

MY COMMISSION EXPIRES:

  
\_\_\_\_\_  
Notary Public:  
Resident County:



Document is  
**NOT OFFICIAL!**  
This Document is the property of  
the Lake County Recorder!

**STOP**

This Instrument Prepared By: Attorney Alicia Gloyeske, 2401 Beech St., Suite E, Valparaiso, Indiana 46383  
(219)464-9224

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.

\_\_\_\_\_  
Alicia Gloyeske





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No 002666

EDR No 000000337649

State No

1. Decedent's Legal Name (First, Middle, Last) <b>DORIS G FULKA</b>				1a. Maiden Name (if female) <b>HARTILIUS</b>		2. Sex <b>FEMALE</b>		3. Time Of Death <b>08:32 PM</b>		4. Date Of Death (Month/Day/Year) <b>08/09/2013</b>			
5. Social Security Number		6a. Age - Yrs <b>86</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>05/19/1927</b>		8. Birthplace (City and State or Foreign Country) <b>HOMEWOOD, IL</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 <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) <b>ST ANTHONY HOSPICE-CROWN POINT</b>													
12. City Or Town, State, And Zip Code <b>CROWN POINT, IN, 46307</b>						13. County Of Death <b>LAKE</b>			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 <b>HOMEMAKER</b>		17. Kind Of Business/Industry <b>OWN HOME</b>			
18. Residence - State <b>INDIANA</b>			18a. County <b>LAKE</b>			18b. City Or Town <b>GRIFFITH</b>			18c. Street And Number <b>434 NORTH RAYMOND STREET</b>		18d. Apt. No.	18e. Zip Code <b>46319</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>JOHN HARTILIUS</b>				23. Mother's Name (First, Middle, Last) <b>JOSEPHINE HARTILIUS</b>				23a. Mother's Maiden Last Name <b>PETERSON</b>					
24. Informant's Name <b>ALAN MANNS</b>				24a. Relationship To Decedent <b>NEPHEW</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>851 VAIL COURT, VALPARAISO, IN 46383</b>							
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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>ANGELCREST CREMATORY</b>			25c. Location - City, Town, And State <b>VALPARAISO, IN</b>							
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>MOELLER FUNERAL HOME INC, 104 ROOSEVELT ROAD, VALPARAISO, IN 46383</b>							27a. Funeral Home License Number <b>FH83006821</b>				
27b. Signature Of Indiana Funeral Service Licensee: <b>MARTIN L. MOELLER, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD01019561</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>END STAGE LYMPHOMA</b>			Due to (Or As A Consequence Of)				
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						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 Findings Available For Review? <input type="checkbox"/> Yes <input checked="" 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				37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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)		38. Street & Number		38c. Apt. No.		38d. Zip Code			
38. Location Of Injury - State						39. Describe How Injury Occurred							
41. Signature, Of Person Certifying Cause Of Death: <b>KATHRYN HENKLE MULLIGAN, 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>KATHRYN HENKLE MULLIGAN, 919 MAIN STREET, SUITE 102, DYER, IN 46311</b>						44. License Number <b>01052342A</b>		45. Date Certified <b>08/12/2013</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>AUG 12 2013</b>							
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)													
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.													



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 002666

EDR No 00000337649

State No

Form containing fields for decedent information (DORIS G FULKA), date of death (08/09/2013), cause of death (END STAGE LYMPHOMA), and certifier information (KATHRYN HENKLE MULLIGAN, SUSAN W. BEST).