

NOT AN OFFICIAL DOCUMENT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, this ~~10th~~ day of December, 2021 Personally appeared: Rebecca A. Martinez and acknowledged the execution of the foregoing deed. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

My commission expires: 01/04/2029

Signature: Keiyomi Thomas
Notary Public:

Resident of: Cook County, Illinois



"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." /s/ Gary P. Bonk

This instrument prepared by: Gary P. Bonk, Attorney, 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800

Cook County Recorder

NOT AN OFFICIAL DOCUMENT



INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Tracking No. 301376

Local No 004686

EDR No 00001196562

State No 2021-066537

1. Decedent's Legal Name (First, Middle, Last) William J. McLaughlin				16. Maiden Name (If female)		2. Gender Male		3. Time Of Death 04:48 PM		4. Date Of Death (Month/Day/Year) 11/14/2021									
5. Social Security Number		6a. Age - Yrs 64		6b. Under 1 Year Months		6c. Under 1 Month Days		6d. Under 1 Day Hours		5a. Under 1 Hour Minutes		7. Date of Birth (Month/Day/Year) 05/31/1957		8. Birthplace (City and State or Foreign Country) Evertgreen Park, Illinois					
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 checked="" 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 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) St. Anthony Medical Center												12. City Or Town, State, And Zip Code Crown Point, Indiana		13. County Of Death Lake		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name				15a. Last Name Before First Marriage				16. Decedent's Usual Occupation Manufacturing Engineer		17. Kind Of Business/Industry Railroad Manufacturer									
18. Residence - State IN				18a. County Lake				18b. City Or Town Crown Point		18c. Street And Number 3402 W Lakeshore Drive		18d. Apt. No.		18e. Zip Code 46307		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 Spanish/Hispanic/Latino				21. Decedent's Race White											
22. Parents Name (First, Middle, Last) John McLaughlin				23. Parents Name (First, Middle, Last) Barbara McLaughlin				23a. Parent's Last Name Before First Marriage Bussio											
24. Informant's Name Rebecca Martinez				24a. Relationship To Decedent Companion				24b. Mailing Address (Street And Number, City, State, Zip Code) 3402 W Lakeshore Drive, Crown Point, IN, 46307											
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) St. Casimir Catholic Cemetery				25c. Place Of Disposition Chicago, IL				25d. Location - City, Town, And State							
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				27. Name And Complete Address Of Funeral Facility Smits Funeral Home 2121 Pleasant Springs Lane, Dyer, Indiana, 46311				27a. Funeral Home License Number: FH11000037											
27b. Signature Of Indiana Funeral Service Licensor: Timothy Smits				Electronically Signed				27c. License Number Of Licensor: FD20600101											
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. Acute hypoxic Respiratory Failure due to lung cancer B. Post Obstructive Pneumonia C. Non small cell Lung Cancer stage 4 D. Approximate Interval - Onset To Death 7 days 7 days NA																			
Part II. Enter Other Significant Conditions Contributing To Death (But Not Mentioned In The Underlying Cause Given In Part I) Atrial fibrillation, Diabetes Mellitus.												29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" 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				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 checked="" 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: Shaoh H. Rasheed				42. Signature (Check Only One): <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				43. License Number 01068300A				45. Date Certified 11/17/2021							
43a. Name, Address And Zip Code Of Person Certifying Cause Of Death: Shaoh H. Rasheed 1201 S Main St, Crown Point, IN 46307				46. Additional Funeral Service Provider:				47. Filer's:				48. For Registrar Only - Date Filed (Month/Day/Year) 11/23/2021							
46. Signature of Local Health Officer: Chandana Varshala				Electronically Signed				AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)				LAKE COUNTY HEALTH OFFICER							