

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 282 085567

Mar 29 1990 Date Issued *Franklin D. Remuda M.D.* Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) Ramon Suarez		2 SEX Male	3a TIME OF DEATH 10:25 a.	3b DATE OF DEATH (Month, Day, Year) March 27, 1990
4 SOCIAL SECURITY NUMBER 467-44-5064	5a AGE—Last Birthday (Years) 65	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Sept 16, 1924
7 BIRTHPLACE (City and State or Foreign Country) Juanacatlan, Mexico	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? —	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) St. Margaret Hospital		9c CITY, TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Raquel Serna	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired!) Steel Worker	12b KIND OF BUSINESS/INDUSTRY Steel	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 4424 Baltimore Avenue	
13e ZIP CODE 46327	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Mexican	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)	18 FATHER'S NAME (First, Middle, Last) Jose Suarez		19. MOTHER'S NAME (First, Middle, Maiden Surname) Marie DeJesus Galvan	
20a INFORMANT'S NAME (Type/Print) Raquel Suarez		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4424 Baltimore, Hammond, Indiana 46327	20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 30, 1990 St. John Cemetery	21c LOCATION—City or Town, State Hammond, Indiana	
22a EMBALMERS NAME Keith D. Anthony		22b EMBALMERS LICENSE NO. 01011911	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b LICENSE NUMBER (of License) 01011911	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz FH 83002835 4404 Cameron, Hammond, IN 46327	
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. APR 12 1990 <i>Keith D. Anthony</i> Congestive Cardiac insufficiency Cardiac Dysrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH April 17 1990		STATE OF INDIANA DEPT. OF HEALTH REC'D
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	28a WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>M. Krad</i>	29c MEDICAL LICENSE NO. 29360	29d DATE SIGNED (Month, Day, Year) March 31, 29, 90.
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) M. Krad, M.D. 509 Ridge Road, Munster, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>			32. DATE FILED (Month, Day, Year) MAR 29 1990	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34f LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. NO		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

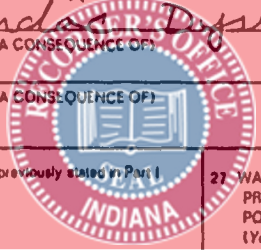
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

Redw bl's Rolling Mills Ind. Rto 35136 b63



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