098687

Local No. 956-90

Rees Funeral
600 W. Ridge Rd
Hobart, Ind 46342

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ROBERT L. WAMPLER AKA BOB L. WAMPLER
2. SEX: MALE
3a. TIME OF DEATH: 11:55 PM
3b. DATE OF DEATH (Month, Day, Yr): APRIL 26, 1990
4. SOCIAL SECURITY NUMBER: 309-20-3785
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): APRIL 9, 1927
7. BIRTHPLACE (City and State or Foreign Country): BLOOMINGTON, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE COUNTY
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): LOUISE KYLE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RETIRED
12b. KIND OF BUSINESS/INDUSTRY: US STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 4400 PARK AVENUE
13e. ZIP CODE: 46405
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): WILLIAM P. WAMPLER
19. MOTHER'S NAME (First, Middle, Maiden Surname): LEOATA FISCH

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LOUISE WAMPLER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4400 PARK AVENUE, LAKE STATION, IN 46405
20c. Relationship: SPOUSE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment X Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 30, 1990 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO: FD01004194
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOMES, INC. FDH3003069 600 W. RIDGE ROAD, HOBART, IN 46342

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. pancreatic carcinoma

DUE TO (OR AS A CONSEQUENCE OF):
b.

DUE TO (OR AS A CONSEQUENCE OF):
c.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

DUE TO (OR AS A CONSEQUENCE OF):

MAY 2 1990

FILED MAY 3 1990

Paul A. Johnson MD

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: atherosclerosis, renal Failure

Anna M. Anton
AUDITOR LAKE COUNTY

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

CERTIFIER

29a. CERTIFIER (Check only one):
XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: E. F. Schulte M.D.
29c. MEDICAL LICENSE NO: 01035204
29d. DATE SIGNED (Month, Day, Year): 5/1/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ERIC SCHULTE, MD, 7863 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul A. Johnson MD
32. DATE FILED (Month, Day, Year): MAY 2, 90

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

Book 50-258-13 Limit 35

4/10

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1