Local No. 426

100387 INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
MAY 14, 1990 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Garrett Leep
2 SEX: Male
3a TIME OF DEATH: 7:20 p.m.
3b DATE OF DEATH (Month Day Yr): May 11, 1990
4 SOCIAL SECURITY NUMBER: 316-07-0981
5a AGE—Last Birthday (Years): 84
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): Oct. 20, 1905
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a WAS DECEDENT A U.S. VETERAN?: N/A
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
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): Trena Van Til
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Delieveryman
12b KIND OF BUSINESS/INDUSTRY: Dairy Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Highland
13d STREET AND NUMBER: 3212 Highway
13e ZIP CODE: 46322
13f INSIDE CITY LIMITS: [ ] No [X] Yes
13g ON A FARM?: [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 4; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): E. K. Leep
19 MOTHER'S NAME (First Middle Maiden Surname): Jennie De Vries

INFORMANT

20a INFORMANT'S NAME (Type/Print): Trena Leep
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3212 Highway Ave. Highland, Indiana
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 14, 1990 Hope Cemetery
21c LOCATION—City or Town, State: Highland, Indiana
22a EMBALMER'S NAME: Edgar Gleim
22b EMBALMER'S LICENSE NO: FDO 1016173
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: (signature) Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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. acute Renal failure
DUE TO (OR AS A CONSEQUENCE OF)
b. arteriosclerotic heart disease with low output
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Atonic urinary bladder. Peptic ulcer
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): —

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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: John Lanman MD
29c MEDICAL LICENSE NO: 18203
29d DATE SIGNED (Month Day Year): May 5/14/90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Lanman, M.D. 716 Seberger Drive, Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. [illegible] M.D.
32 DATE FILED (Month Day Year): MAY 14 1990

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.

FILED
MAY 17 1990

(signature) Recorder Lake County 4.0

Highland Park Manor L17+18 Blk.3 Unit 16 Key #27-116-17
Schell Rd Add L.8 Unit 9 Key #11-189-8

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

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