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

MAY 30, 1990 — Date Issued — Hammond Health Commissioner

Local No. 470 104409

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ALBERT CARL ROSE JR.
2. SEX: Male
3a. TIME OF DEATH: 6:52P M.
3b. DATE OF DEATH (Month, Day, Yr.): May 28, 1990
4. SOCIAL SECURITY NUMBER: 303-48-2049
5a. AGE—Last Birthday (Years): 45
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): OCT 3, 1944
7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1966
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'S HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS: Married
11. SURVIVING SPOUSE (If wife, give maiden name): SANDRA KORUSCHAK
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): LOAN OFFICER
12b. KIND OF BUSINESS/INDUSTRY: ASSOCIATE FINANCE CO.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 181 S. PENNSYLVANIA
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No [X] Yes
13g. ON A FARM?: [X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): ; College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): ALBERT C. ROSE SR.
19. MOTHER'S NAME (First, Middle, Maiden Surname): RUBY A. DARLING

INFORMANT

20a. INFORMANT'S NAME (Type/Print): SANDRA ROSE
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 181 S. PENNSYLVANIA ST., HOBART, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 31, 1990 EVERGREEN MEMORIAL PARK
21c. LOCATION—City or Town, State: HOBART, IN 46342
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FDO1004194
23. WAS DEATH REPORTED TO CORONER?: [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOME 600 W. OLD RIDGE RD, HOBART, IN 46342

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. Diabetic End Stage Renal Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Gangrene of Foot with
DUE TO (OR AS A CONSEQUENCE OF):
c. Below Knee Amputation
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.

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): 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: James Greenwald MD
29c. MEDICAL LICENSE NO: 20603
29d. DATE SIGNED (Month, Day, Year): MAY 30/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JAMES GREENWALD MD, 5454 HOHMAN AVE., HAMMOND, INDIANA 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Premuda M.D.
32. DATE FILED (Month, Day, Year): MAY 30 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 JUN 01 1990

Oscar R. Arton
AUDITOR LAKE COUNTY

Stamp: FILED FOR RECORD JUN 6 1990 LAKE COUNTY RECORDER, STATE OF INDIANA S.S. NO.

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

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Hobart Park Add N 60ft L6 Bl2 unit 27 Key#18-34-6

P.A. Rees 600 W Ridge Rd Hobart 46342

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