13C

92054482

Local No. 91-0296

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Key# 49-294-5
Oak Ridge Park Add
Corrected Plat
State No. 415 & 416 Bk 13

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Tammy	Roedel	Female	7:50p	April 6, 1991

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
315-76-7459	28			June 23, 1962	Crossmore, N. Car.

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No		HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Northlake Campus	Gary	Lake

10 MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Ronnie Roedel	Manager	Crown Majestic

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	2420 Hobart St.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46406	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	1

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Ronnie Jones	Gipsie Brewer

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State Zip Code)	20c Relationship
Ronnie Roedel	2420 Hobart St. Gary, In 46406	Husband

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	April 10, 1991 Calumet Park Cemetery	Merrillville, Ind.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Anthony S. Rendina Jr.	FD01010402	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Anthony Rendina Jr	FD01010402	Rendina F. Home FH 83007819 5100 Cleveland St. Gary, In

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 Vascular collapse	Unknown
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	b DUE TO (OR AS A CONSEQUENCE OF) Pending toxicology analysis and further study.	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d DUE TO (OR AS A CONSEQUENCE OF)	

PART II Other significant conditions contributing to death but not previously stated in Part I

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

CERTIFIER

29a CERTIFIER (Check only one)
☐ AUDITOR LAKE COUNTY 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Daniel D. Thomas M.D.	16120	April 8, 1991

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Robert L. Pate MD	APR. 9 1991

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☒ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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
April 6, 1991	