

93045316

INDIANA STATE DEPARTMENT OF HEALTH

Local No: 1587-93

CERTIFICATE OF DEATH

State No:

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK-INK

1 DECEASED—NAME (First Middle Last) Ruby P. Cumberlin		2 SEX Female	3a TIME OF DEATH 3:30p	3b DATE OF DEATH (Month Day Yr) June 18, 1993	
4 SOCIAL SECURITY NUMBER 478-26-4982	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) May 22, 1923	
7 BIRTHPLACE (City and State or Foreign Country) Eureka, Iowa	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? None	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) Munster Med-Inn		9c CITY, TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Robert Cumberlin	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 18239 Madison		
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify) White	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5 +) 12		18 FATHER'S NAME (First Middle Last) William Kapaska			
19 MOTHER'S NAME (First Middle Maiden Surname) Dolly Ratledge		20a INFORMANT'S NAME (Type/Print) Robert Cumberlin			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) This Document is the property of Indiana the Lake County Recorder		20c Relationship Husband			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) June 21, 1993 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Scherverville, Indiana	
22a EMBALMER'S NAME James Porras		22b EMBALMER'S LICENSE NO 1045964		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a LICENSE NUMBER (of Licenses) 1045184		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Ave Munster, Indiana 46319			
26 PART I: Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) 2-1993 Cause of Death: <i>Cardiovascular</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Arteriosclerosis</i> CONDITIONS (Any which give rise to the immediate cause of death) <i>Arteriosclerosis, Myocardial Infarction</i> LAKE COUNTY HEALTH COMMISSIONER					
27 WAS DECEDENT PREGNANT, OR 90 DAYS POSTPARTUM? (Yes or no) No					
28a 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>Robert Cumberlin</i>			
29c MEDICAL LICENSE NO 1W.20248		29d DATE SIGNED (Month, Day, Year) 6/18/93			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) W.V. HEBERMAN, MD 7505 CALUMET AVE MUNSTER IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>				32 DATE FILED (Month, Day, Year) June 22, 1993	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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			

DECEDENT

PARENTS

INFORMANT

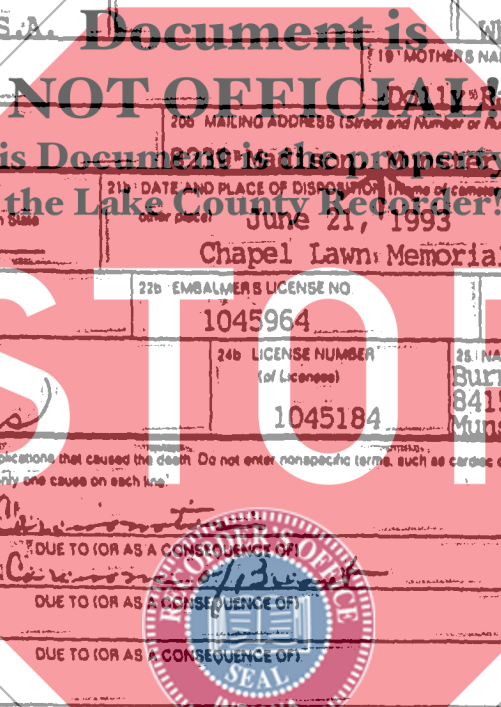
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH OF RUBY P. CUMBERLIN, AS FILED WITH THE LAKE COUNTY HEALTH DEPT.

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