94028926

Sweeney, Dakagia, Conoghue
709 Franklin Square P.O. Box 769
Michigan City, IN 46360

TRUE COPY OF RECORD OF REGISTRATION ON FILE AT LA PORTE COUNTY HEALTH DEPARTMENT

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 074

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Albert L. Cummins
2. SEX: Male
3a. TIME OF DEATH: 2:10A.M
3b. DATE OF DEATH (Month, Day, Yr): February 20, 1994
4. SOCIAL SECURITY NUMBER: 355-09-0520
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): May 22, 1909
7. BIRTHPLACE (City and State or Foreign Country): Lawrenceville, Illinoi
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? No
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Life Care Center
9c. CITY, TOWN OR LOCATION OF DEATH: Michigan City
9d. COUNTY OF DEATH: LaPorte
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Bernice Jackson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Roofer
12b. KIND OF BUSINESS/INDUSTRY: Construction
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Cedar Lake
13d. STREET AND NUMBER: 12736 Maple St.
13e. ZIP CODE: 46303
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 10; College (1-4 or 5+)

ISSUED FEB 2 2 1994

PARENTS

18. FATHER'S NAME (First, Middle, Last): Clint Cummins
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Weathers

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Bernice Cummins
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12736 Maple St., Cedar Lake, In. 46303
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 23, 1994 German Methodist Cemetery
21c. LOCATION—City or Town, State: Cedar Lake, Indiana
22a. EMBALMER'S NAME: Fred Oparka
22b. EMBALMER'S LICENSE NO.: FD01016076
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Fred Oparka
24b. LICENSE NUMBER (of Licensee): FD01016076
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Eller Brady FH83000825, Cedar Lake, Indiana 46303

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): arteriosclerotic heart disease		
CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE (A) STATING THE UNDERLYING CAUSE LAST: (A) dementia		
DUE TO (OR AS A CONSEQUENCE OF):		
DUE TO (OR AS A CONSEQUENCE OF):		

FILED APR 12 1994

RECORDER'S OFFICE LA PORTE COUNTY, IN. 8 56 AM '94

24-100-17

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

Anna M. Cisna AUDITOR LAKE COUNTY

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): No

CERTIFIER

29a. CERTIFIER (Check only one):
☒ 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: Dennis E Frazier M.D.
29c. MEDICAL LICENSE NO: IN 25352
29d. DATE SIGNED (Month, Day, Year): 2/21/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dennis E. Frazier, M.D. 231 Medical Plaza, Michigan City, IN 46360

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: K Aggarwal MD
31. DATE FILED (Month, Day, Year): FEB 22 1994

FILED APR 12 1994

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.

Anna M. Cisna

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