94030869

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No: 0002-93

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): Earle G. Gummerson
- 2 SEX: male
- 3a TIME OF DEATH: 6:00 a.M.
- 3b DATE OF DEATH (Month Day Yr): January 3, 1993
- 4 SOCIAL SECURITY NUMBER: 371-18-0068
- 5a AGE—Last Birthday (Years): 75
- 5b UNDER 1 YEAR (Months / Days):
- 5c UNDER 1 DAY (Hours / Minutes):
- 6 DATE OF BIRTH (Mo Day Yr): May 27, 1917
- 7 BIRTHPLACE (City and State or Foreign Country): Homestead, Wisconsin
- 8a WAS DECEDENT A U.S. VETERAN?: Yes WWII
- 8b YEAR LAST SERVED IN US ARMED FORCES?: 1945
- 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): 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): Dorothy Haderman
- 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Electrical Maint.
- 12b KIND OF BUSINESS/INDUSTRY: Inland Steel
- 13a RESIDENCE—STATE: Indiana
- 13b COUNTY: Lake
- 13c CITY, TOWN OR LOCATION: Highland
- 13d STREET AND NUMBER: 8116 4th Place West
- 13e ZIP CODE: 46322
- 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): 12; College (1-4 or 5+): 3

PARENTS

- 18 FATHER'S NAME (First Middle Last): Gustaf Gummerson
- 19 MOTHER'S NAME (First Middle Maiden Surname): Silverd Sjoquist

INFORMANT

- 20a INFORMANT'S NAME (Type/Print): Mrs. Dorothy E. Gummerson
- 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8116 4th Pl. W. Highland, IN 46322
- 20c Relationship: Wife

DISPOSITION

- 21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
- 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 7, 1993 Calumet Park Cemetery
- 21c LOCATION—City or Town, State: Merrillville, IN
- 22a EMBALMER'S NAME: David F. McCoy
- 22b EMBALMER'S LICENSE NO: FD08700581
- 23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
- 24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
- 24b LICENSE NUMBER (of Licensee): FD01013507
- 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FH83002801, 7042 Kennedy Ave., Hammond, IN 46323

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Metastatic Colon Ca — Approximate Interval Between Onset and Death:

DUE TO (OR AS A CONSEQUENCE OF):

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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: Diabetes Mellitus II

- 27 WAS DECEDENT PREGNANT OR 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: J. Perez M.D.
- 29c MEDICAL LICENSE NO: 01027498
- 29d DATE SIGNED (Month Day Year): 1/04/93
- 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. J. Perez, 7905 Calumet Ave., Munster, IN 46321

HEALTH OFFICER

- 31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.
- 32 DATE FILED (Month Day Year): January 4, 1993

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.

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FILED APR 25 1994

Anna M. Antone AUDITOR LAKE COUNTY

Lot 3 Homestead Hundred 2nd add to Highland 27-252-31

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCERIPD 1