

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0842-94

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED-NAME (First Middle Last) RICHARD R TROUTMAN SR
2 SEX MALE
3a TIME OF DEATH 3:27 A
3b DATE OF DEATH (Month Day Year) APRIL 4, 1994
4 SOCIAL SECURITY NUMBER 304 36 7332
5a AGE-Last Birthday (Yearly) 57
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr) MARCH 18, 1937
7 BIRTHPLACE (City and State or Foreign Country) MONTGOMERY ALABAMA
8a WAS DECEDENT A U.S. VETERAN? NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
8c PLACE OF DEATH (Check only one See instructions)
HOSPITAL [] Inpatient [] ER/Outpatient [] DOA
OTHER [] Nursing Home [] Other (Specify) Residence

DECEDENT

9b FACILITY NAME (If not institution, give street and number) 1141 PETTIBONE STREET
9c CITY TOWN OR LOCATION OF DEATH CROWN POINT
9d COUNTY OF DEATH LAKE
10 MARITAL STATUS (Specify) MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name) LUPE V VILLAGRAN
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) INSTRUMENT REPAIRMAN
12b KIND OF BUSINESS/INDUSTRY U.S. STEEL GARY WORKS
13a RESIDENCE-STATE INDIANA
13b COUNTY LAKE
13c CITY TOWN OR LOCATION CROWN POINT
13d STREET AND NUMBER 1141 PETTIBONE STREET

PARENTS

13e ZIP CODE 46307
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? [] No [] 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+) 95001575

INFORMANT

18 FATHER'S NAME (First Middle Last) BENJAMIN TROUTMAN
19 MOTHER'S NAME (First Middle Maiden Surname) CHRISTINE MINICH

DISPOSITION

20a INFORMANT'S NAME (Type/Print) LUPE V TROUTMAN
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1141 PETTIBONE ST, CROWN POINT, IN 46307
20c Relationship WIFE
21a METHOD OF DISPOSITION [] Entombment [X] Burial [X] Cremation [] Removal from State [] Donation [] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) APRIL 16, 1994 NORTHWEST IND. CREMATION SERVICE
21c LOCATION-City or Town, State CROWN POINT INDIANA

CAUSE OF DEATH

22a BREADER'S NAME N/A
22b EMBALMER'S LICENSE NO N/A
23 WAS DEATH REPORTED TO CORONER? [X] No [] Yes
24a SIGNATURE OF FUNERAL DIRECTOR (Signature)
24b LICENSE NUMBER (of Licensee) 1009461
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10101 Broadway Crown Point, In 46307 FDH83002445

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 adenocarcinoma of unknown primary
DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any which gave rise to the immediate cause, stating the underlying cause first.
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) NO
28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO
28b WERE AUTOPSY FINDINGS REPORTED TO YOU BY THE PHYSICIAN? (Yes or no) N/A

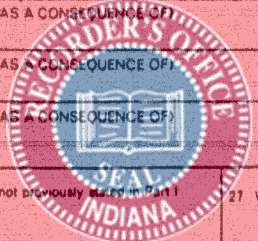
CERTIFIER

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 (Signature)
29c MEDICAL LICENSE NO 01036259
29d DATE SIGNED (Month Day Year) 04-06-94

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. J. H. Gleason, 7905 Calumet Avenue, Munster, IN 46321
31 HEALTH OFFICER'S SIGNATURE (Signature)
32 DATE FILED (Month Day Year) April 8, 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
000405900



STATE OF INDIANA LAKE COUNTY REC'D FOR RECORD AMASA G. COLEMAN CHIEF DEP. RECORDER

Key # 9-389-15