45-363-40

Local No. 92-0244

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): James A. Plummer		2. SEX: Male	3a. TIME OF DEATH: 1:37 pm	3b. DATE OF DEATH (Month, Day, Yr.): March 29, 1992	
4. SOCIAL SECURITY NUMBER: 494-07-5920	5a. AGE—Last Birthday (Years): 67	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo., Day, Yr.): May 17, 1924	7. BIRTHPLACE (City and State or Foreign Country): Austin, Texas
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1941	9a. PLACE OF DEATH: HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center		9c. CITY, TOWN OR LOCATION OF DEATH: Gary		9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): Clyde E. Weaver	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Custodian		12b. KIND OF BUSINESS/INDUSTRY: School City of Gar	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN OR LOCATION: Gary		13d. STREET AND NUMBER: 1531 Fillmore	
13e. ZIP CODE: 46407	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): Black	17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Clarence Plummer	19. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Hampton

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Clyde E. Plummer	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1531 Fillmore/Gary, Indiana 46407	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 3, 1992 Fern Oaks Cemetery	21c. LOCATION—City or Town, State: Griffith, Indiana
22a. EMBALMER'S NAME: Samuel Smith, Jr.	22b. EMBALMER'S LICENSE NO.: FDE01019692	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Samuel Smith Jr.	24b. LICENSE NUMBER (of Licensee): FDE01019692	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Divinity Memorial Chapel 3820 Pulaski/East Chicago, 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. Acute Respiratory Arrest / CHF
DUE TO (OR AS A CONSEQUENCE OF):
b. COPD / Pulmonary Emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c. Multi-organ Failure / Dehydration
DUE TO (OR AS A CONSEQUENCE OF):
d.

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	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? 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: Cirully Llaneta M.D.	29c. MEDICAL LICENSE NO.: 01030385	29d. DATE SIGNED (Month, Day, Year): 4/2/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): CYRILL M. LLANETA, M.D. 26 E. 15th Ave. Gary IN 46407

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Rebecca E. Foster mDmpHHSc	32. DATE FILED (Month, Day, Year): APR. 2 1992

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 FEB 28 1995

SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

95012080

[illegible] original document, of which this
photocopy, appears to be genuine and
unaltered [illegible] to have been made at the
time purported. This photocopy consists
of 1 page.

Signature

Date 4/8/93 Title SK