

45-363-40

INDIANA STATE BOARD OF HEALTH  
CERTIFICATE OF DEATH

Local No. 92-024A

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle Last) <b>James A. Plummer</b>		2 SEX <b>Male</b>	3 TIME OF DEATH <b>11:37 pm</b>	3b DATE OF DEATH (Month Day Year) <b>March 29, 1992</b>	
4 SOCIAL SECURITY NUMBER <b>494-07-5920</b>	5a AGE—Last Birthday (Year) <b>67</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) <b>May 17, 1924</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Austin, Texas</b>	8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1941</b>	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA 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) <b>St. Mary Medical Center</b>		9c CITY TOWN OR LOCATION OF DEATH <b>Gary</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Clyde E. Weaver</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most or working life. Do not use retired) <b>Custodian</b>	12b KIND OF BUSINESS/INDUSTRY <b>School City of Gary</b>		
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Gary</b>	13d STREET AND NUMBER <b>1531 Fillmore</b>		
13e ZIP CODE <b>46407</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>Black</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		18 FATHER'S NAME (First Middle Last) <b>Clarence Plummer</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Marie Hampton</b>		20a INFORMANT'S NAME (Type/Print) <b>Clyde E. Plummer</b>			
20b HOME ADDRESS (Street and Rural Route, Box, P.O. Number, City or Town, State, Zip Code) <b>1531 Fillmore/Gary, Indiana 46407</b>		20c Relationship <b>Wife</b>			
21a MODE OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>April 3, 1992 Fern Oaks Cemetery</b>		21c LOCATION—City or Town, State <b>Griffith, Indiana</b>	
22a EMBALMER'S NAME <b>Samuel Smith, Jr.</b>		22b EMBALMER'S LICENSE NO. <b>FDE01019692</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Samuel Smith Jr.</i>		24b LICENSE NUMBER (of Licensee) <b>FDE01019692</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Divinity Memorial Chapel 3820 Pulaski/East Chicago, IN</b>		
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 (First disease or condition resulting in death) <b>Acute Respiratory Arrest / CHF</b>		Approximate Interval Between Onset and Death			
DUE TO (OR AS A CONSEQUENCE OF) <b>COPD / Pulmonary Emphysema</b>		FILED			
DUE TO (OR AS A CONSEQUENCE OF) <b>Multi-organ Failure / Dehydration</b>		FEB 28 1992			
DUE TO (OR AS A CONSEQUENCE OF)		MARCH 2 1992			
DUE TO (OR AS A CONSEQUENCE OF)		STATE OF INDIANA			
DUE TO (OR AS A CONSEQUENCE OF)		LAKE COUNTY			
DUE TO (OR AS A CONSEQUENCE OF)		FILED FOR RECORD			
DUE TO (OR AS A CONSEQUENCE OF)		SAM O'BRIEN COUNTY CLERK			
DUE TO (OR AS A CONSEQUENCE OF)		AUDITOR LAKE COUNTY			
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) <b>No</b>		28a WAS AN AUTOPSY PERFORMED PRIOR TO DEATH (Yes or no) <b>No</b>		28b WAS AN AUTOPSY PERFORMED AFTER DEATH (Yes or no) <b>No</b>	
29a CERTIFIER (Check only one) <input 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>Cheryl Clanton, R.N.</i>			
29c MEDICAL LICENSE NO. <b>01030385</b>		29d DATE SIGNED (Month Day Year) <b>4/2/92</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>CYRILL M. LLANETA, M.D. 26 G. 15th Ave. Gary IN 46407</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Robert E. Justice, M.D. M.P.H.C.</i>				32 DATE FILED (Month Day Year) <b>APR 2 1992</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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) <b>001366</b>			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS  
INFORMANT

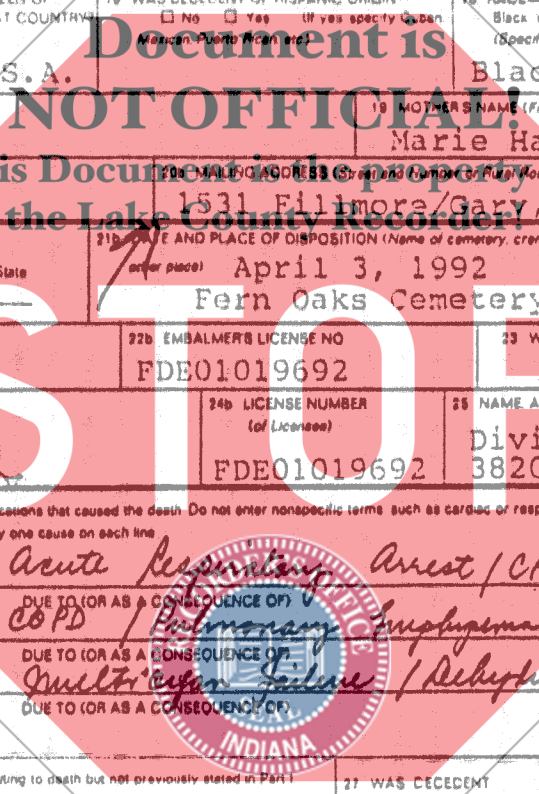
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER  
USE ONLY



95090821

FILED  
FEB 28 1992  
MARCH 2 1992  
STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
SAM O'BRIEN COUNTY CLERK  
AUDITOR LAKE COUNTY

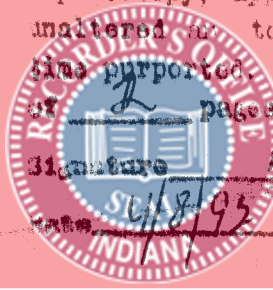
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Signature

*White*

Date 5/18/93

Title SK