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

Local No. 434

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

34-253-58

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

June 15 1995 Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ALFREDO M. JAYME
2. SEX: MALE
3a. TIME OF DEATH: 3:48 PM
3b. DATE OF DEATH (Month, Day, Yr.): JUNE 10, 1995
4. SOCIAL SECURITY NUMBER: 316-42-2712
5a. AGE—Last Birthday (Years): 53
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day Yr.): NOV. 6, 1941
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1968
8c. 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): ST. MARGARET MERCY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CHRISTEL KRUGMANN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): POLICE OFFICER
12b. KIND OF BUSINESS/INDUSTRY: CITY OF HAMMOND
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 4429 PINE AVENUE
13e. ZIP CODE: 46327
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): MEXICAN
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+): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last): JESUS JAYME
19. MOTHER'S NAME (First, Middle, Maiden Surname): SUSAN BUELL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CHRISTEL JAYME
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4429 PINE AVENUE, HAMMOND, IN 46327
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JUNE 15, 1995 OAKLAND MEMORY LANES CREMATORY
21c. LOCATION—City or Town, State: DOLTON, ILLINOIS
22a. EMBALMER'S NAME: KEITH D. ANTHONY
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835, 4404 CAMERON, HAMMOND, IN 46327

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):
a. Cardio-pulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Occlusion
DUE TO (OR AS A CONSEQUENCE OF):
c.
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): YES
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: B.M.F. Palmer M.D.
29c. MEDICAL LICENSE NO.: 01018484
29d. DATE SIGNED (Month, Day, Year): JUNE 6/15/95

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): B.M.F. PALMER, M.D. 5815 CALUMET AVENUE, HAMMOND, INDIANA 46320
31. HEALTH OFFICER'S SIGNATURE: Franklin D. Armendariz M.D.
32. DATE FILED (Month, Day, Year): JUNE 15, 1995

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED: 000317
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.

900

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

STATE OF INDIANA, LAKE COUNTY FILED FOR RECORD
95 JUL 6 PM 3:25
MARY BELL RECORDER

FILED
JUL 6 1995
SAM ORLICH
AUDITOR LAKE COUNTY

RECEIVED
JUL 6 1995
RECORDER'S OFFICE SEAL INDIANA

BC 3
LOTS 42 & 43
LAKE'S ADD
RETURN TO: 7150 Indianapolis Blvd. Hammond, IN - 46324 Attn: Peter Katie