

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

STATE OF INDIANA
LAKE COUNTY

CERTIFICATE OF DEATH

FILED FOR RECORD

Local No. 2000-99

Key No. 4-5-45-15 812

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL 99084382

282317
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Raymond F. Rinkenberger		2 SEX Male		3 TIME OF DEATH 01:45P		4 DATE OF DEATH (Month Day Year) August 26, 1999	
4 SOCIAL SECURITY NUMBER 304-34-3928		5a AGE—Last Birthday (Year) 78		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Month Day Year) Apr 5, 1921		7 BIRTHPLACE (City and State or Foreign Country) Hebron, IN					
8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) St. Marys Medical Center				9c CITY, TOWN OR LOCATION OF DEATH Hobart		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married		11 SURVIVING SPOUSE ATrice Becker		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Farmer		12b KIND OF BUSINESS/INDUSTRY Farming	
13a RESIDENCE—STATE IN		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hebron		13d STREET AND NUMBER 15928 S. Grove Rd.	
13e ZIP CODE 46341		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
13g ON A FARM? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		16 RACE—American Indian, Black, White, etc. (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 12			
18 FATHER'S NAME (First Middle Last) William Rinkenberger				19 MOTHER'S NAME (First Middle Maiden Surname) Clara Burow			
20a INFORMANT'S NAME (Type/Print) Alice Rinkenberger		20b MAILING ADDRESS (Street or Rural Route Number, City or Town, State, Zip Code) Hebron, IN 46341				20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) August 30, 1999 South East Grove Cemetery				21c LOCATION—City or Town, State Hebron, IN	
22a EMBALMER'S NAME Molly E. Tucker Hawkins		22b EMBALMER'S LICENSE NO. FD09200061		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FD08900045		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN			
26 PART I: IMMEDIATE CAUSE OF DEATH (Final disease or condition resulting in death) Do not enter nonspecific terms, such as cardiac or respiratory. List all causes of death on each line. (Specify only highest grade completed.) IMMEDIATE CAUSE (Final disease or condition resulting in death) SEP 02 1999 <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. <i>Dependent (Hillman) mtd</i> LAKE COUNTY HEALTH COMMISSIONER							
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Intra cerebral bleed Aneurysm - intracerebral</i>							
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a WAS AN AUTOPSY PERFORMED? (Yes or no)		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)			
29a CERTIFIER (Check only one) <input checked="" 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>[Signature]</i>		29c MEDICAL LICENSE NO. 01031652		29d DATE SIGNED (Month Day Year) 8/31/99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Charles Rebesco, 1400 S. Lake Park Ave., Suite 405, Hobart, IN 46342							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Hillman MD</i>						32 DATE FILED (Month Day Year) September 2, 1999	
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		34a 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) 9:00 P.M. E.P. 05			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 00767					

DECEDENT

PARENTS

INFORMANT

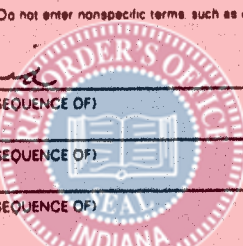
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

NOT OFFICIAL
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FILED

OCT 13 1999

PETER BENJAMIN
LAKE COUNTY ADDITOR