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

AUG 2, 1999 — Franklin Bremuda — Date Issued — Hammond Health Commissioner

* 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.

Local No. 600

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): JOHN E. KINGERY
2. SEX: MALE
3a. TIME OF DEATH: 1:05 PM
3b. DATE OF DEATH (Month Day Yr): JULY 30, 1999
4. *SOCIAL SECURITY NUMBER: 316-24-9110
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): JULY 17, 1927
7. BIRTHPLACE (City and State or Foreign Country): Rocky Point, VA
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1948
9a. 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): Residence: 2533-171st Street
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): Roberta Arndt
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance
12b. KIND OF BUSINESS/INDUSTRY: Calumet College
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 2533-171st Street
13e. ZIP CODE: 46323
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): white
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): James B. Kingery
19. MOTHER'S NAME (First, Middle, Maiden Surname): Obelia Ovacre

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mrs. Roberta Kingery
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2533-171st St. Hammond, IN 46323
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): August 4, 1999 Northwest Indiana Cremation Serv.
21c. LOCATION (City, Town, State): Crown Point, IN
22a. EMBALMER'S NAME: C. William McCoy
22b. EMBALMER'S LICENSE NO.: FD01013612
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01013507
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

FILED OCT 26 1999 PETER BENJAMIN LAKE COUNTY AUDITOR

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Heart attack Myocardial Infection	immediate
DUE TO (OR AS A CONSEQUENCE OF) b	COPD	many years
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): no
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: Janice M. Flharety MD
29c. MEDICAL LICENSE NO.: 01050816
29d. DATE SIGNED (Month Day Year): 8/2/1999
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JANICE M. FLHARETY, M.D. 5500 HOHMAN AVE., HAMMOND, INDIANA 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin Bremuda M.D.
32. DATE FILED (Month Day Year): August 2, 1999

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.

99 OCT 26

99 066785

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