

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.

STATE OF INDIANA
INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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

Local No. ... 38

JAN 15 1999
Date Issued
Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

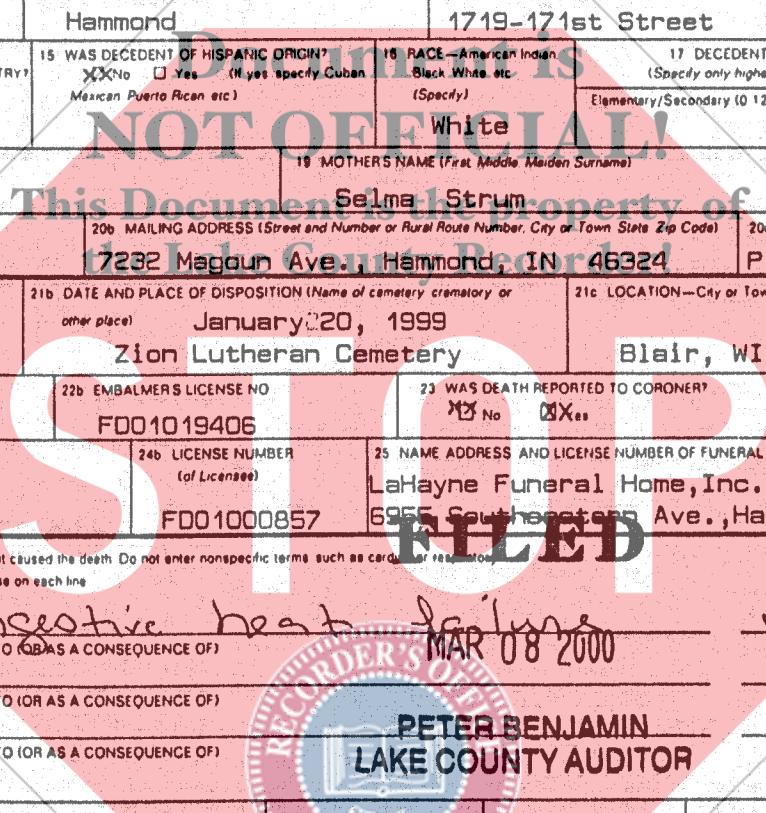
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (Last, First, Middle Initial) Norma C. Renning		2 SEX Female	3a TIME OF DEATH 5:30P. M.	3b DATE OF DEATH (Month Day Yr) January 13, 1999
4 SOCIAL SECURITY NUMBER 389-16-2631	5a AGE—Last Birthday (Years) 88	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) August 29, 1910
7 BIRTHPLACE (City and State or Foreign Country) Blair, WI	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 checked="" 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. Margaret Mercy, North Campus		9c CITY TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Single	11 SURVIVING SPOUSE (If wife give maiden name) None	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Teacher		12b KIND OF BUSINESS/INDUSTRY School City of Hammond
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond		13d STREET AND NUMBER 1719-171st Street
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (12) College (1-4 or 5+) 6		18 FATHER'S NAME (First Middle Last) Ole Renning		
19 MOTHER'S NAME (First Middle Maiden Surname) Selma Strum		20a INFORMANT'S NAME (Type/Print) Rev. James A. Swanson		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7232 Magoun Ave., Hammond, IN 46324		20c Relationship P.O.A.		
21a METHOD 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) January 20, 1999 Zion Lutheran Cemetery		21c LOCATION—City or Town, State Blair, WI
22a EMBALMER'S NAME Henry J. Blake		22b EMBALMER'S LICENSE NO. FD01019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edwin B. Feltguy</i>		24b LICENSE NUMBER (of Licensee) FD01000857		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc., FH1940000E 6955 Southeastern Ave., Hammond, IN 46324
26 PART I Enter the diseases, injuries or complications that caused the death. Do not enter nonspecific terms such as cardiac 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. <i>Constrictive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF)		
Conditions if any which gave rise to the immediate cause, stating the underlying cause last		b. _____ DUE TO (OR AS A CONSEQUENCE OF)		
		c. _____ DUE TO (OR AS A CONSEQUENCE OF)		
		d. _____ DUE TO (OR AS A CONSEQUENCE OF)		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
<i>renal failure</i>		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO
<i>Fracture of left femur</i>				28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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>Kenneth J. Ramsey, M.D.</i>		29c MEDICAL LICENSE NO. 02000963		29d DATE SIGNED (Month Day Year) 1/14/99
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) <i>Kenneth J. Ramsey, M.D., 24 Juliet Rd Dyer, Ind.</i>				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Premuda, M.D.</i>				32 DATE FILED (Month Day Year) January 15, 1999
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 <i>9:00 P.M.</i>		
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) <i>60771</i>		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>9:00 P.M.</i>		
34g DATE PHONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no). If yes specify driver, passenger, pedestrian, etc. <i>Ti</i>		



Handwritten notes on the left margin: 'KH 34-339-19', 'MULLIS', 'THOR HO 920000636'.