Key # 36-479-8

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

Local No. 696

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Sept. 3, 1999
Date Issued

Franklin D. Brenneke Jr. MD
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED-NAME (First Middle Last): EUNICE A. LARAMIE
2 SEX: Female
3a TIME OF DEATH: 4:48 PM
3b DATE OF DEATH (Month Day Yr): September 1, 1999
4 SOCIAL SECURITY NUMBER: 314-52-7682
5a AGE - Last Birthday (Years): 49
5b UNDER 1 YEAR (Months Days):
5c UNDER 1 DAY (Hours Minutes):
6 DATE OF BIRTH (Mo Day Yr): Oct 10, 1949
7 BIRTHPLACE (City and State or Foreign Country): CHICAGO HEIGHTS, IL
8a WAS DECEDENT A U S VETERAN?: No
8b YEAR LAST SERVED IN U S ARMED FORCES: N/A
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): 2635-169TH 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): RALPH J. LARAMIE
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): HOMEMAKER
12b KIND OF BUSINESS INDUSTRY: OWN HOME
13a RESIDENCE - STATE: IN
13b COUNTY: LAKE
13c CITY TOWN OR LOCATION: HAMMOND
13d STREET AND NUMBER: 3234-176TH STREET
13e ZIP CODE: 46323
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.)
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+): 1

PARENTS

18 FATHER'S NAME (First, Middle, Last): ALBERT HESTERMAN
19 MOTHER'S NAME (First, Middle, Maiden Surname): NORMA SASS

INFORMANT

20a INFORMANT'S NAME (Type/Print): RALPH J. LARAMIE
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3234-176TH STREET, HAMMOND, IN 46323
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sep 4, 1999 CHAPEL LAWN MEMORIAL GARDENS
21c LOCATION - City or Town State: Schererville, IN
22a EMBALMER'S NAME: C. WILLIAM MCCOY
22b EMBALMER'S LICENSE NO: FDO1013612
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FDO1042047
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83002801 BOCKE FUNERAL HOME, INC. 7042 KENNEDY AVENUE, Hammond, IN 46323

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Ventricular fibrillation — MAR 30 2000
DUE TO (OR AS A CONSEQUENCE OF)
b. myocardial infarct
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d. coronary artery disease

Conditions if any which gave rise to the immediate cause stating the underlying cause last

PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Diabetes Mellitus
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: [signature]
29c MEDICAL LICENSE NO: 31576
29d DATE SIGNED (Month Day Year): Sept. 3 '99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Won Loh, M.D. 9134 Columbia Avenue Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Brenneke M.D.
32 DATE FILED (Month Day Year): September 3 1999

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 HOW INJURY OCCURRED
34e PLACE OF INJURY - At home, farm, street, factory, office building, etc (Specify)
34f LOCATION (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

2215 9.00 AM
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SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1