Key # 46-115-38

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.

5CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 013202 State No. .....

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): Albert Sumbry
2 SEX: Male
3a TIME OF DEATH: 8:50 a M
3b DATE OF DEATH (Month, Day, Yr.): January 5, 2002
4 *SOCIAL SECURITY NUMBER: 419-36-1690
5a AGE—Last Birthday (Years): 68
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Mo. Day. Yr.): July 3, 1933
7 BIRTHPLACE (City and State or Foreign Country): Phenix City, Alabama
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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Emily Rowe
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Security Guard
12b KIND OF BUSINESS/INDUSTRY: ~~SAM~~
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 981 Matthews Street
13e ZIP CODE: 46406
13f INSIDE CITY LIMITS: [ ] No [X] Yes
13g ON A FARM?: [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc (Specify): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): M.C. Sumbry Sr.
19 MOTHER'S NAME (First, Middle, Maiden Surname): Lula Feggans

INFORMANT

20a INFORMANT'S NAME (Type/Print): Emily Sumbry
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 981 Matthews Street Gary, Indiana 46406
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 10, 2002 Evergreen Cemetery
21c LOCATION—City or Town, State: Hobart, Indiana
22a EMBALMER'S NAME: Patrician Owens
22b EMBALMER'S LICENSE NO.: #08700298
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Carmella Perry
24b LICENSE NUMBER (of Licensee): #29700070
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Director, Inc. 2959 West 11th Avenue Gary, Indiana 46404 83007704

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. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF): b. pneumonia
DUE TO (OR AS A CONSEQUENCE OF): c. lung cancer
DUE TO (OR AS A CONSEQUENCE OF): d.

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

Approximate Interval Between Onset and Death

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):

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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: Joel Lopez M.D.
29c MEDICAL LICENSE NO: 01045471
29d DATE SIGNED (Month, Day, Year): 1/11/02
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOEL LOPEZ, M.D. 5495 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: PETER BENJAMIN LAKE COUNTY AUDITOR
32 DATE FILED (Month, Day, Year): January 18, 2002

33 MANNER OF DEATH: [X] 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.