*** 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. 101

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

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

Feb 11 2002 — Date Issued — Franklin F. Grenuda M.D. — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): RICHARD L. SIMMONS
2. SEX: Male
3a. TIME OF DEATH: 01:27 PM
3b. DATE OF DEATH (Month, Day, Yr): February 8, 2002
4. *SOCIAL SECURITY NUMBER: 317-32-6778
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): October 20, 1933
7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED U.S. ARMED FORCES?: 1957
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): 7130 MADISON AVENUE
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): DIANE THORN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Supervisor Elec. Meter Shop
12b. KIND OF BUSINESS/INDUSTRY: NIPSCO
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 7130 MADISON AVENUE
13e. ZIP CODE: 46324
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
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): LEORY SIMMONS
19. MOTHER'S NAME (First, Middle, Maiden Surname): ETHEL DOWNING

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DIANE SIMMONS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7130 MADISON AVENUE, HAMMOND, IN 46324
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Feb 12, 2002 ELMWOOD CEMETERY
21c. LOCATION (City or Town, State): HAMMOND 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: Leroy L. Bocken
24b. LICENSE NUMBER (of Licensee): FDO1042047
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BOCKEN FUNERAL HOME, INC. FH83002801 7042 KENNEDY AVENUE, HAMMOND, IN

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. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Peripheral Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Obstructive Pulmonary Disease
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: Previous Coronary Artery Bypass Surgery

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: Richard L. Good MD
29c. MEDICAL LICENSE NO: 01027057
29d. DATE SIGNED (Month, Day, Year): 2/11/02 (February)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RICHARD L. GOOD, M.D. 7905 CALUMET AVENUE, MUNSTER, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin F. Grenuda M.D.
32. DATE FILED (Month, Day, Year): February 11, 2002

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. DESCRIBE HOW INJURY Ooccurred:
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.

FILED
2002 MAY 14 PM 2:20
PETER BENJAMIN
LAKE COUNTY AUDITOR
RECORDER
0852

SDH06-004 State Form 10110 (R5/1-99)

9.00 cp
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