

ATTENTION ESTATE: Disclosure of the decedent's assets is required by law. If we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No. ....

Local No. 232-01

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

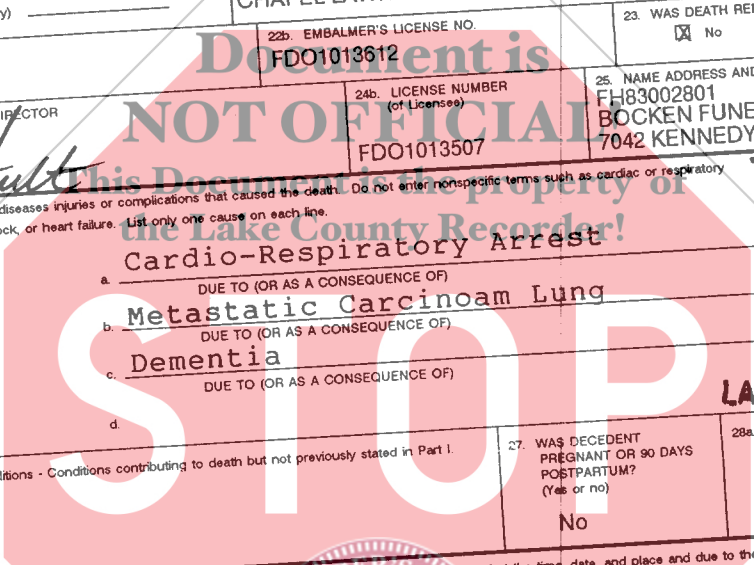
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) <b>ALBERTA RUHS</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>6:15PM</b>	3b. DATE OF DEATH (Month Day Yr) <b>January 29, 2001</b>
4. SOCIAL SECURITY NUMBER <b>353-09-4800</b>		5. AGE - Last Birthday (Years) <b>93</b>	6. UNDER 1 DAY Hours Minutes <b>4:00</b>	7. DATE OF BIRTH (Mo Day Yr) <b>Jul 11, 1907</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES <b>-</b>		9. BIRTHPLACE (City and State or Foreign Country) <b>CARTHAGE, IL</b>
9a. PLACE OF DEATH (Check only one) (See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		9b. CITY TOWN OR LOCATION OF DEATH <b>HOBART</b>		9c. COUNTY OF DEATH <b>LAKE</b>
9d. FACILITY NAME (If not institution, give street and number) <b>SEBO'S REHABILITATION CENTER</b>				12b. KIND OF BUSINESS INDUSTRY <b>OWN HOME</b>
10. MARITAL STATUS (Specify) <b>Widowed</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>HOMEMAKER</b>
13a. RESIDENCE - STATE <b>IN</b>		13b. COUNTY <b>LAKE</b>		13c. CITY TOWN OR LOCATION <b>HOBART</b>
13d. STREET AND NUMBER <b>4410 W. 49TH AVENUE</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>		
13e. ZIP CODE <b>46342</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		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) <b>WHITE</b>
18. FATHER'S NAME (First, Middle, Last) <b>N/A RAYBOURN</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA McMAHAN</b>		
20a. INFORMANT'S NAME (Type/Print) <b>TERRY RUHS</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3545 JEWETT STREET, HIGHLAND, IN 46322</b>		20c. Relationship <b>SON</b>
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>Feb 1, 2001 CHAPEL LAWN MEMORIAL GARDENS</b>		21c. LOCATION - City or Town State <b>SCHERERVILLE, IN</b>
22a. EMBALMER'S NAME <b>C. WILLIAM MCCOY</b>		22b. EMBALMER'S LICENSE NO. <b>FDO1013612</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of License) <b>FDO1013507</b>		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, HAMMOND, IN 46323</b>
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. <b>Cardio-Respiratory Arrest</b> <b>Metastatic Carcinoma Lung</b> <b>Dementia</b>				
26. 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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>-</b>
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) and manner 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>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>(1031797)</b>		29d. DATE SIGNED (Month Day Year) <b>February 1, 2002</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>S. RANE, M.D., 10 N. MICHIGAN AVENUE, HOBART, IN 46342</b>				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day Year)		34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)		34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		
34e. LOCATION (Street and Number or Rural Route Number City or Town State) <b>FEB 11 7:00</b>		34f. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. DATE FILED (Month Day Year) <b>JUL 12 2002</b>		



**FILED**

Unit #16  
Key #27-14-63  
At E/S/SE/SW S.22 T.36 R.9 D.50AC

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M.L.  
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