

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to insure its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. *Key # 28-131-16*

Local No. *1101-03*

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) Larry C. Wambsganss		2 SEX Male	3a TIME OF DEATH 7:15 A M	3b DATE OF DEATH (Month Day Yr) November 14, 2003	
4 *SOCIAL SECURITY NUMBER 299-36-4895	5a AGE—Last Birthday (Years) 60	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) August 2, 1943	
7 BIRTHPLACE (City and State or Foreign Country) Van Wert, OH	8a WAS DECEDENT A U.S. VETERAN? No				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		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, South Campus		9c CITY, TOWN, OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Shirley Robbins	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Civil Engineer	12b KIND OF BUSINESS/INDUSTRY Self Employed		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Munster	13d STREET AND NUMBER 1315 Ridge Road		
13e ZIP CODE 46321	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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5		18 FATHER'S NAME (First Middle Last) Frederick C. Wambsganss			
19 MOTHER'S NAME (First Middle Maiden Surname) Ruth Bricker			20a INFORMANT'S NAME (Type/Print) Shirley Wambsganss		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1315 Ridge Road, Munster, IN 46321		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) November 18, 2003 Fairview Cemetery		21c LOCATION (City or Town, State) Dyersburg, TN	
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 type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edna B. ...</i>		24b LICENSE NUMBER (of Licensee) FD01000857	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc. #19400005 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 or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a Pancreatic Cancer DUE TO (OR AS A CONSEQUENCE OF) b DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) d					
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) 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>[Signature]</i>			29c MEDICAL LICENSE NO. 62001515	29d DATE SIGNED (Month Day Year) November 17, 2003	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Christopher J. McIntire, DO, 3831 Hohman Ave., Hammond, IN 46327					
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>			32 DATE FILED (Month Day Year) November 17, 2003		
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) MAR 1 2004	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
34e TYPE OF INJURY—At home, farm, street, factory, office, etc. (Specify) 000076		34f LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34g DATE PRONOUNCED DEAD (Month Day Year) NOPE					
34h TYPE OF VEHICLE ACCIDENT (Specify driver, passenger, pedestrian, etc.)					