* **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. 121

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

MAR 4, 2004 Date Issued — Hammond Health Commissioner

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): CARL G. RUMPS, JR.
2. SEX: MALE
3a. TIME OF DEATH: 9:10 P.M.
3b. DATE OF DEATH (Month, Day, Yr.): FEBRUARY 15, 2004
4. *SOCIAL SECURITY NUMBER: 311-36-4682
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): JUNE 3, 1938
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1964
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): ST. MARGARET MERCY
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): DOLORES JACK
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): INSPECTOR
12b. KIND OF BUSINESS/INDUSTRY: CONTINENTAL INSURANCE
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 6627 JACKSON AVENUE
13e. ZIP CODE: 46324
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): CARL G. RUMPS, SR.
19. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE MARION ALGER

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DOLORES RUMPS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6627 JACKSON AVE., HAMMOND, INDIANA 46324
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 20, 2004 SOLAN-PRUZIN CREMATORY
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: DEAN G. WAGNER
22b. EMBALMER'S LICENSE NO: 8800057
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Dean G Wagner
24b. LICENSE NUMBER (of Licensee): 8800057
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN-PRUZIN FUNERAL HOME FH83002893, 7109 CALUMET AVE., HAMMOND, IN. 46324

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.	intracranial bleed	less than 1 week
DUE TO (OR AS A CONSEQUENCE OF): b.	respiratory failure	less than 1 week
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

FILED FEB 2 2004

STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Chronic renal failure, Dementia, Congestive heart failure

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
AUTOPSY PERFORMED (Yes or no): NO
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: Alfred Noghnogh
29c. MEDICAL LICENSE NO: 01045772
29d. DATE SIGNED (Month, Day, Year): FEBRUARY 17, 2004

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A.A. NOGH NOGH, M.D. 450 EAST OHIO STREET, CHICAGO, IL. 312-654-2700

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Sremuda M.D.
32. DATE FILED (Month, Day, Year): February 17, 2004

ref Key # 35-5-21

33. MANNER OF DEATH: ☐ 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 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.

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1