* **ATTENTION ESTATE:** Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 20053-01

392981

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. Key# 27-17-9-93

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

10cc 2 Net 12 total

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased - Name (First Middle Last)	JAMES D. FLEMING
2. Sex	Male
3a. Time of Death	5:20AM
3b. Date of Death (Month Day Yr)	September 17, 2001
4. Social Security Number	310-36-6126
5a. Age - Last Birthday (Years)	64
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo Day Yr)	March 24, 1937
7. Birthplace (City and State or Foreign Country)	Gary, Indiana
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces	1963
9a. Place of Death (Check only one. See instructions)	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	162 Fraser Lane
9c. City Town or Location of Death	Hobart
9d. County of Death	Lake
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	Olga Hodko
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Finisher
12b. Kind of Business Industry	Manufacturing
13a. Residence - State	Indiana
13b. County	Lake
13c. City Town or Location	Hobart
13d. Street and Number	162 Fraser Lane
13e. Zip Code	46342
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
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

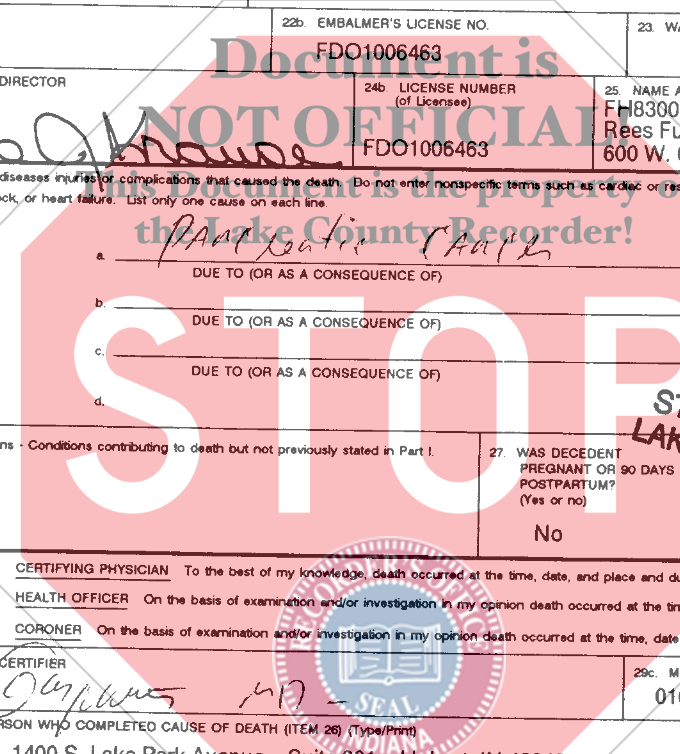
Field	Entry
18. Father's Name (First, Middle, Last)	James Fleming
19. Mother's Name (First, Middle, Maiden Surname)	Edith Arnold

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Olga Fleming
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	162 Fraser Lane, Hobart, IN 46342
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory or other place)	September 20, 2001 Calvary Crematory
21c. Location - City or Town State	Portage, Indiana
22a. Embalmer's Name	James J. Krause
22b. Embalmer's License No.	FDO1006463
23. Was Death Reported to Coroner?	☐ No ☒ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FDO1006463
25. Name Address and License Number of Funeral Home	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342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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. Heart Attack
DUE TO (OR AS A CONSEQUENCE OF)

b.
DUE TO (OR AS A CONSEQUENCE OF)

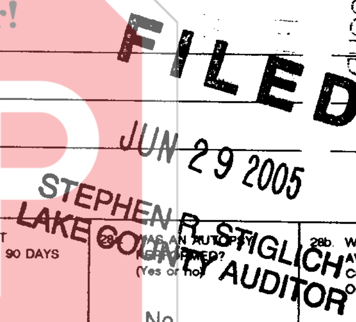
c.
DUE TO (OR AS A CONSEQUENCE OF)

d.

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

Field	Entry
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


FILED
JUN 29 2005
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

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.

Field	Entry
29b. Signature and Title of Certifier	[signature] MD
29c. Medical License No	01037515
29d. Date Signed (Month Day Year)	9-18-01
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	Milton Gasparis MD, 1400 S. Lake Park Avenue, Suite 301, Hobart, IN 46342

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Susan W. Burt D.O.
32. Date Filed (Month Day Year)	September 18, 2001

Field	Entry
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 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.	

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