

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 2007-0066-0004

Local No. 1596-07

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED - NAME (First, Middle, Last)<br>John E. Bruce  |  | 2. SEX<br>Male  | 3a. TIME OF DEATH<br>4:05 PM  | 3b. DATE OF DEATH (Month, Day, Yr.)<br>June 15, 2007   |  |
| 4. SOCIAL SECURITY NUMBER<br>310-44-3131   | 5a. AGE - Last Birthday (Years)<br>63  | 5b. UNDER 1 YEAR<br>Months: Days: Hours: Minutes:   | 5c. UNDER 1 DAY<br>Hours: Minutes:  | 6. DATE OF BIRTH (Mo., Day, Yr.)<br>March 04, 1944   |  |
| 8a. WAS DECEASENT A U.S. VETERAN?<br>No  |  | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?  |   | 7. BIRTHPLACE (City and State or Foreign Country)<br>Knoxville Tennessee                       |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br>Methodist Hospital - South Lake Campus   |  | 9c. CITY, TOWN, OR LOCATION OF DEATH<br>Merrillville  |   | 9d. COUNTY OF DEATH<br>Lake  |  |
| 10. MARITAL STATUS (Specify)<br>Married  | 11. SURVIVING SPOUSE (If wife, give maiden name)<br>Sandra Young                               | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)<br>Ironworker                |   | 12b. KIND OF BUSINESS/INDUSTRY<br>Construction   |  |
| 13a. RESIDENCE - STATE<br>Indiana  | 13b. COUNTY<br>Lake  | 13c. CITY, TOWN OR LOCATION<br>Merrillville   | 13d. STREET AND NUMBER<br>7712 Taft St  |  |  |
| 13e. ZIP CODE<br>46410   | 13f. INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14. CITIZEN OF WHAT COUNTRY?<br>USA   | 15. WAS DECEASENT OF HISPANIC ORIGIN?<br><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)<br>White                              |  |
| 18. FATHER'S NAME (First, Middle, Last)<br>Marshell Edward Bruce   |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Ruby Branham  |   |  |  |
| 20a. INFORMANT'S NAME (Type/Print)<br>Sandra Lynn Bruce  |  | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7712 Taft St, Merrillville, IN 46410   | 20c. Relationship<br>Wife   |  |  |
| 21a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <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)<br>June 21, 2007<br>Ashland Cemetery                   |   | 21c. LOCATION - City or Town, State<br>Ashland, Kentucky                                       |  |
| 22a. EMBALMER'S NAME<br>James F. Burns   |  | 22b. EMBALMER'S LICENSE NO.<br>01009461   | 23. WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes   |  |  |
| 24a. SIGNATURE OF FUNERAL DIRECTOR<br><i>James F. Burns</i>  |  | 24b. LICENSE NUMBER (of Licensee)<br>FD0100946  | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br>Burns Funeral Home FH83002380<br>701 E. 7th Street, Hobart, Indiana 46342-                               |  |  |
| 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)<br>a. Acute + chronic congestive heart failure<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |   | 1-3 days   |  |
| b. Massive liver necrosis<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |   | weeks  |  |
| c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |   |  |  |
| d. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |   |  |  |
| PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I  |  | 27. WAS DECEASENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U)<br>No   | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no)<br>Yes   | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)<br>Yes |  |
| 29a. CERTIFIER (Check only one)<br><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.<br><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.<br><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<br><i>James F. Burns MD</i>  |  | 29c. MEDICAL LICENSE NO.<br>01048374A   | 29d. DATE SIGNED (Month, Day, Year)<br>6-20-07  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br>James Bryant, MD<br>333 N. Michigan #3400 Chicago 60601  |  |   |   |  |  |
| 31. HEALTH OFFICER'S SIGNATURE<br><i>Susan W. Best, D.O.</i>   |  |   |   | 32. DATE FILED (Month, Day, Year)<br>June 15, 2007   |  |
| 33. MANNER OF DEATH<br><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)<br>JUN 28 2007   | 34b. TITLE OF INJURY AT WORK? (Yes or no)   | 34c. DESCRIBE HOW INJURY OCCURRED  |  |
| 34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)<br>123330   |  | 34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 34g. DATE PRONOUNCED DEAD (Month, Day, Year)<br>June 15, 2007  |  | 34h. MOTOR VEHICLE ACCIDENT? (Yes or No) (Yes, specify driver, passenger, pedestrian, etc.)<br>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR |   |  |  |