

2-635023-5-C

Mary Capora

TYPE OR PRINT
MAINLY WITH
FADING INK
THIS IS A
PERMANENT
RECORD

JUL 2

Lucie O. [Signature]
AUDITOR LAKE COUNTY

Local No. 80-0781

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No. _____

06

F.R. Maas & Mollard
all 845 W 15, S. 46 E. 10, S. 44 B1

46-5745

LICENSE No. 972

FUNERAL DIRECTOR'S LICENSE No. 1785

EMBALMER'S NAME Clinton Williams

FUNERAL DIRECTOR'S SIGNATURE John R. Williams

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

PARENTS

DISPOSITION

M.D. OR D.O.

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

1 DECEASED—NAME FIRST MIDDLE LAST Eddie Mae Brown		2 SEX Female	3 DATE OF DEATH (MONTH, DAY, YEAR) 9-27-1980
4 RACE—(e.g. White, Black, American Indian, etc.) (Specify) Black	5a AGE—Last Birthday (Yrs) 54	5b UNDER 1 YEAR MOS DAYS	5c UNDER 1 DAY HOURS MINS
6 CITY, TOWN OR LOCATION OF DEATH Gary		7a HOSPITAL OR OTHER INSTITUTION—Name (if not in either, give street and number) Methodist Hospital	7b IF HOSP. OR INST. Indicate LOA, OP/Emar. Rm., Inpatient (Specify) Inpatient
8 STATE OF BIRTH (if not in U.S.A. name country) Ila.	9 CITIZEN OF WHAT COUNTRY U.S.A.	10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	11 SURVIVING SPOUSE (if wife, give maiden name) No
12 SOCIAL SECURITY NUMBER 314-26-6833		13 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	14 KIND OF BUSINESS OR INDUSTRY Home
15a RESIDENCE—STATE Ind.	15b COUNTY Lake	15c CITY, TOWN OR LOCATION Gary	
16 STREET AND NUMBER 3514 W. 30th Pl.		17 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18 IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19 FATHER—NAME FIRST MIDDLE LAST Lee Wilson		20 MOTHER—MAIDEN NAME FIRST Channie	
21a INFORMANT—NAME (Type or print) Angela Williams		21b MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN 3514 W. 20th Pl. Gary, Ind. 46404	
22a BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		22b CEMETERY OR CREMATORY—FUNERAL HOME LOCATION CITY OR TOWN STATE Fern Oaks Cemetery Griffith, Ind. 46312	
23a DATE (MONTH DAY YEAR) 10-3-1980		23b FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Hinton-Williams 4859 Alexander Ave. East Chicago, Ind. 46312	
24 To the best of my knowledge, death occurred at (time, date and place and due to the cause(s) stated) [Signature] J. Albert Carey M.D.		25 DATE SIGNED (Mo., Day, Yr.) 9-30-80	26 HOUR OF DEATH 6:30 P
27 NAME OF ATTENDING PHYSICIAN (Type or Print) J. Albert Carey, M.D.		28 MAILING ADDRESS—PHYSICIAN 2764 W 11th AVE, Gary, Ind. 46404	
29 HEALTH OFFICER—SIGNATURE E. N. Callahan		30 DATE RECEIVED BY LOCAL HEALTH OFFICER SEP 30 1980	
31 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c)) (a) Acute Pulmonary Edema (b) Bronchial Asthma		32 Interval between onset and death 3 days 20-25 yrs	
33 OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		34 AUTOPSY (Specify Yes or No) No	

STATE OF INDIANA
FILED
JUL 28 AM 1981
RECORDED

Disposition Permit Issued
Provisional Certificate
 Yes No

MP

CERTIFIED COPY

E. M. Caldwell, M.D.

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE SEP 30 1980