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EMBALMER'S NAME SHERMAN G BANKS III  
LICENSE No. *Sherman G Banks 1625*  
FUNERAL DIRECTOR'S SIGNATURE *Sherman G Banks*  
AUDITOR LAKE COUNTY FUNERAL HOME  
LICENSE No. 1625  
FUNERAL DIRECTOR'S LICENSE No. 1625

640466  
Local No. *81-0602*

# INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

*Betty Jean Lane*

619

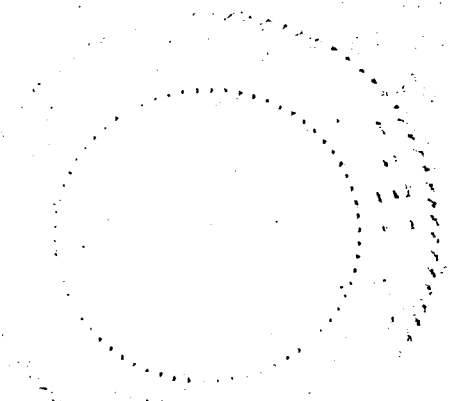
State No.

DECEASED—NAME 1. ELIZBETH DOUGLAS			SEX 2. FEMALE	DATE OF DEATH (MONTH, DAY, YEAR) 3. AUGUST 8, 1981
RACE—(a) White, Black, American Indian, etc. (Specify) 4. AMER. BLK.	AGE—Last Birthday (Yrs) 5a. 68	UNDER 1 YEAR 5b. MOS	UNDER 1 DAY 5c. HOURS MINS	DATE OF BIRTH (Mo., Day, Yr.) 6 21 OCT., 1912
CITY, TOWN OR LOCATION OF DEATH 7b. GARY		HOSPITAL OR OTHER INSTITUTION—Name (If not in other, give street and number) 7c. GARY MERCY MEDICAL CENTER		COUNTY OF DEATH 7d. LAKE
STATE OF BIRTH (If not in U.S.A. name country) 8. GEORGIA	CITIZEN OF WHAT COUNTRY 9. U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10. MARRIED	SURVIVING SPOUSE (If wife, give maiden name) 11. CLETION DOUGLAS	IF HOSP OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify) 7d. INPATIENT
SOCIAL SECURITY NUMBER 13. 309-16-8319		USUAL OCCUPATION (Give kind of work done during most of working life even if retired) 14a. HOUSEWIFE	KIND OF BUSINESS OR INDUSTRY 14b. HOMEMAKER	
RESIDENCE—STATE 15a. INDIANA	COUNTY 15b. LAKE	CITY, TOWN OR LOCATION 15c. GARY		IS RESIDENCE ON A FARM? 15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
STREET AND NUMBER 15d. 1277 WEST 17th AVENUE		INSIDE CITY LIMITS (SPECIFY YES OR NO) 15f. YES		
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
FATHER—NAME 16. HERMAN THERMAN			MOTHER—MAIDEN NAME 17. LULA BELL GILBERT	
INFORMANT—NAME (Type or print) 18a. CLETION DOUGLAS (HUSBAND)		RELATIONSHIP	MAILING ADDRESS 18b. 1277 WEST 17th AVENUE	CITY OR TOWN GARY
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. BURIAL		CEMETERY OR CREMATORY—FUNERAL HOME 19b. FERN OAKS CEMETERY	LOCATION 19c. GRIFFITH	CITY OR TOWN INDIANA
DATE (MONTH, DAY, YEAR) 20a. AUGUST 13, 1981		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 20b. SMITH, BIZZELL & WARNER INC. 2295 WASH. ST. GARY, IND. 46407		
To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. 21a. (Signature) <i>Rodolfo M. Almase</i>			DATE SIGNED (Mo., Day, Yr.) 21b.	HOUR OF DEATH 21c. 11 13 AM '81
NAME OF ATTENDING PHYSICIAN (Type or Print) 21d. DR. RODOLFO ALMASE, M.D.			DATE RECEIVED BY LOCAL HEALTH OFFICER 22b. AUG 14 1981	
MAILING ADDRESS—PHYSICIAN 21e. 904 WEST RIDGE ROAD HOBART, INDIANA 46342				
HEALTH OFFICER—SIGNATURE 22a. <i>E. N. Caldwell, M.D.</i>				
23. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c))				
PART I (a) Hemorrhagic shock			Interval between onset and death	
(b) Bleeding tumor with esophageal mass			Interval between onset and death	
(c) Renal failure; intra abdominal mass			Interval between onset and death	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)			AUTOPSY (Specify Yes or No) 24	

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CERTIFIED  
*E. H. Caldwell, M.D.*  
HEALTH COMMISSIONER  
CITY OF GARY, IND.  
DATE AUG 14 1981