

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPT.

TYPE OR PRINT PLAINLY WITH UNFADING INK
THIS IS A PERMANENT RECORD

Below for State Office

Disposition Permit Issued / /
Provisional Certificate
 Yes No

EMBALMER'S NAME: John L. Alexander
FUNERAL DIRECTOR'S SIGNATURE: John L. Alexander
LICENSE NO.: 1061
FUNERAL HOME: GENERAL HOME

DECEASED OCCURRED IN INSTITUTION? SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

DECEASED SIGNATURE: Daniel D. Thomas, M.D.
FUNERAL HOME: V.W. Huber
ADDRESS: 7051 Kennedy
CITY: Hammond, IN
STATE: IN
ZIP: 46329

**INDIANA STATE BOARD OF HEALTH
CORONER'S CERTIFICATE OF DEATH**

Local No. 225

State 2824 Ralston St. No. July 4/6406

DECEASED—NAME 1. NELLIE M. TATE		SEX 2. Female	DATE OF DEATH (MONTH, DAY, YEAR) 3. October 2, 1985
RACE—(If White, Black, American Indian, etc.) 4. White	AGE—Last Birthday (Mo.) 5a. 88	UNDER 1 YEAR 5b. 88	DATE OF BIRTH (Mo., Day, Yr.) 6. 5/30/1897
CITY, TOWN OR LOCATION OF DEATH 7b. Hammond		HOSPITAL OR OTHER INSTITUTION—(Name if not in other, give street and number) 7c. St. Margaret Hospital	
STATE OF BIRTH (If not in U.S.A. name country) 8. Indiana	CITIZEN OF WHAT COUNTRY 9. U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10. Widowed	DATE OF BIRTH (Mo., Day, Yr.) 7a. Lake
SOCIAL SECURITY NUMBER 13. 313-12-9479	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a. Janitric (Retired)	KIND OF BUSINESS OR INDUSTRY 14b. General American Co.	
RESIDENCE—STATE 15a. Indiana	COUNTY 15b. Lake	CITY, TOWN OR LOCATION 15c. Hammond	
STREET AND NUMBER 15d. 4311 Clark St.		IS RESIDENCE ON A FARM? 15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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. William Liddington		MOTHER—MAIDEN NAME 17. Sara Watson	
INFORMANT—NAME RELATIONSHIP 18a. Charlotte Tate (Daughter)		MAILING ADDRESS 18b. 4311 Clark St., Hammond, IN 46327	
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. Burial		CEMETERY OR CREMATORY—FUNERAL HOME 19b. Oak Hill Cemetery	
DATE (MONTH, DAY, YEAR) 20a. October 5, 1985		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE) 20b. V. Huber Funeral Home, 7051 Kennedy, Hammond, IN	
On the basis of examination and/or investigation, in my opinion death occurred in the same date and place and due to the causal cause. 21a. Signature Daniel D. Thomas, M.D. by [Signature]		DATE SIGNED (Mo., Day, Yr.) 21b. 10/4/85	HOUR OF DEATH 21c. 10:10 P.M.
NAME AND ADDRESS OF CERTIFIER (Type or Print) 21d. DANIEL D. THOMAS, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN. 46307		PRONOUNCED DEAD (Mo., Day, Yr.) 21e. 10/2/85	
HEALTH OFFICER—SIGNATURE 22a. Franklin J. Remuda, M.D.		DATE RECEIVED BY LOCAL HEALTH OFFICER 22b. OCT - 4 1985	
IMMEDIATE CAUSE 23a. Severe coronary artery disease; Congestive heart failure		Interval between onset and death Undetermined	
DUE TO, OR AS A CONSEQUENCE OF: (a) Failure		Interval between onset and death	
DUE TO OR AS A CONSEQUENCE OF: (b)		Interval between onset and death	
DUE TO OR AS A CONSEQUENCE OF: (c)		Interval between onset and death	
OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART 1 (a) 24. Yes		AUTOPSY (Specify Yes or No) 24. Yes	
ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 25a. Natural	DATE OF INJURY (Mo., Day, Yr.) 25b.	HOUR OF INJURY 25c. M	DESCRIBE HOW INJURY OCCURRED 25d.
INJURY AT WORK (Specify Yes or No) 25e.	PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 25f.	LOCATION 25g.	LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE