Oak Park add L21 Bl 14
Key # 46-112-21

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. MC143 — 971685

State No.

TRUE COPY OF RECORD OF REGISTRATION ON FILE AT LA PORTE COUNTY HEALTH DEPARTMENT

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: FIRST C. P. MIDDLE Starks LAST Ellis
2 SEX: Female
3 DATE OF DEATH (Mo. Day Yr): March 26, 1988
4 SOCIAL SECURITY NUMBER: 311-26-1742
5a AGE—Last Birthday (Years): 75
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Month Day Year): 4-25-1912
7 BIRTHPLACE (City and State or Foreign Country): Mississippi
8 YEAR LAST SERVED IN US ARMED FORCES?: N/A
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): St Anthony's Hospital
9c CITY, TOWN OR LOCATION OF DEATH: Michigan City
9d COUNTY OF DEATH: LaPorte
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Joseph Ellis
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laundress
12b KIND OF BUSINESS/INDUSTRY: St. Mary's Medical Cente
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2482 Delaware St.
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: NO
13g ZIP CODE: 46407
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify:
15 RACE—American Indian, Black, White, etc. (Specify): Black
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)

PARENTS

17 FATHER'S NAME (First, Middle, Last): Ross Bradford
18 MOTHER'S NAME (First, Middle, Maiden Surname): Amanda Brown

INFORMANT

19a INFORMANT'S NAME (Type/Print): Joseph Ellis
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2482 Delaware St. GARY, IN, LAKE, 46407
19c Relationship: husband

DISPOSITION

20a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 31, 1988 Eveergreen Cemetery
20c LOCATION—City or Town, State: Hobart, IN
21a SIGNATURE OF FUNERAL DIRECTOR: Patricia Owens
21b LICENSE NUMBER (of Licensee): 8700298
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors Inc. 2959 W. 11th Ave. #3007704 Gary, IN

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: Julius P. Rivera
23b LICENSE NUMBER: 01025525
23c DATE SIGNED (Month, Day, Year): 3-27-88

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH
24 TIME OF DEATH: 6:01p.m.
25 DATE PRONOUNCED DEAD (Month, Day, Year): 3-26-88
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): no

CAUSE OF DEATH — SEE INSTRUCTIONS

27. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Pulmonary failure, pneumonia
DUE TO (OR AS A CONSEQUENCE OF)
b. Chronic Obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Bleeding stress gastric ulcer
28a WAS AN AUTOPSY PERFORMED? (Yes or no): 2
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

FILED
APR 8

CERTIFIER — SEE INSTRUCTIONS

29a CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated
☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated

Anna N. Anton — AUDITOR LAKE COUNTY

MAR 31 1988

29b SIGNATURE AND TITLE OF CERTIFIER: Julius P. Rivera, MD
29c LICENSE NUMBER: 1025525
29d DATE SIGNED (Month, Day, Year): 3-27-88
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Julius P. Rivera, M.D. 1715 Buffalo St. Michigan City, IN 46360

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: James Lorcher, M.D.
32 DATE FILED (Month, Day, Year): 3-31-88

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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)

BP 3-31-88

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SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1