

INDIANA STATE BOARD OF HEALTH

600

Locat No. 88-0095 974760

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1. DECEASED—NAME FIRST MIDDLE LAST
ALEAN ROSEMOND

2. SEX: FEMALE 3. DATE OF DEATH (Mo. Day, Yr): FEBRUARY 5, 1988

4. SOCIAL SECURITY NUMBER: 415-28-5886 5a. AGE—Last Birthday: 69 5b. UNDER 1 YEAR: Months Days 5c. UNDER 1 DAY: Hours Minutes 6. DATE OF BIRTH (Month, Day, Year): 8-25-1918 7. BIRTHPLACE (City and State or Foreign Country): ALABAMA

8. YEAR LAST SERVED IN U.S. 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): 2324 Tennessee St. 9c. CITY, TOWN, OR LOCATION OF DEATH: Gary 9d. COUNTY OF DEATH: Lake

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married 11. SURVIVING SPOUSE (If wife, give maiden name): E.L. Rosemond 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife 12b. KIND OF BUSINESS/INDUSTRY:

13a. RESIDENCE—STATE: Indiana 13b. COUNTY: Lake 13c. CITY, TOWN, OR LOCATION: Gary 13d. STREET AND NUMBER: 2324 Tennessee 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 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+)

17. FATHER'S NAME (First, Middle, Last): Arthur Brown 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Minor

19a. INFORMANT'S NAME (Type/Print): E. L. Rosemond 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2324 Tennessee St. Gary, Indiana 19c. Relationship: Husband

20a. METHOD OF DISPOSITION: Burial Cremation Removal from State Donation Other (Specify) 20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 2-10-88 Evergreen Cemetery 20c. LOCATION—City or Town, State: Hobart, IN

21. SIGNATURE OF FUNERAL DIRECTOR: [Signature] 21b. LICENSE NUMBER (of Licensee): 8700298 22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Fun. Dir. Inc. 2959 W. 11th Ave. #3007704

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title < [Signature] 23b. LICENSE NUMBER: APR 28 11 43 AM '88 23c. DATE SIGNED (Month, Day, Year): APR 28 11 43 AM '88

24. TIME OF DEATH: 1:35 P. M. 25. DATE PRONOUNCED DEAD (Month, Day, Year): February 5, 1988 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Coronary Arteriosclerotic heart and vascular disease DUE TO (OR AS A CONSEQUENCE OF) b. Diabetes DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. APR 28 1988

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN (Physician certifying cause of death and pronouncing death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. [Signature] 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [Signature] 29c. LICENSE NUMBER: 16120 29d. DATE SIGNED (Month, Day, Year): February 8, 1988

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Daniel D. Thomas, M.D. 293 N. Main Street, Crown Point, Indiana 46307

31. HEALTH OFFICER'S SIGNATURE: [Signature] 32. DATE FILED (Month, Day, Year):

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)

KEY# 103-1
I RAN LOOK UP WITH A
ALL LOT @ EXC. N. 10 FT
N 20 FT LOT 7

RECORDED
LILLIAN A. BLASTICK

FILED

Karen Freeman 817 Tellmore

1553

067143

067143

067143

RECEIVED OF
Wm. T. Redick, Jr.
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE FEB 11 1900