

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. 1896 Chase St

Local No. 88-0117
974827

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCED BY 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: **JOAN HODGES** (FIRST, MIDDLE, LAST)
 2. SEX: **Female**
 3. DATE OF BIRTH: **FEBRUARY 13, 1988**
 4. SOCIAL SECURITY NUMBER: **311-05-5447**
 5a. AGE—Last Birthday (Years): **64**
 5b. UNDER 1 YEAR: Months: Days: Hours: Minutes:
 5c. UNDER 1 DAY: Hours: Minutes:
 6. DATE OF BIRTH (Month, Day, Year): **March 24 1908**
 7. BIRTHPLACE (City and State or Foreign Country): **Helena, Arkansas**
 8. YEAR LAST SERVED IN U.S. ARMED FORCES: **NO**
 9a. PLACE OF DEATH (Check only one. See instructions):
 HOSPITAL: Inpatient ER/Outpatient OOA OTHER: Nursing Home Residence Other (Specify):
 9b. FACILITY NAME (If not institution, give street and number): **ST MARY MEDICAL CENTER - 540 TYLER**
 9c. CITY, TOWN, OR LOCATION OF DEATH: **GARY, INDIANA**
 9d. COUNTY OF DEATH: **LAKE**
 10. MARITAL STATUS—Married Never Married Widowed Divorced
 SURVIVING SPOUSE (If wife, give maiden name): **ARTHUR HODGES**
 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life): **Lampshade Maker**
 12b. KIND OF BUSINESS/INDUSTRY: **Private**
 13a. RESIDENCE—STATE: **INDIANA**
 13b. COUNTY: **LAKE**
 13c. CITY, TOWN, OR LOCATION: **GARY**
 13d. STREET AND NUMBER: **896 CHASE STREET**
 13e. INSIDE CITY LIMITS? (Yes or no): **YES**
 13f. FARM: **NO**
 13g. ZIP CODE:
 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No Yes: **BLACK**
 15. RACE—American Indian, Black, White, etc. (Specify):
 16. DECEDENT'S EDUCATION (Specify only highest grade completed):
 Elementary/Secondary (10-12) College (1-4 or 5+)
 17. FATHER'S NAME (First, Middle, Last): **Charlie Murphy**
 18. MOTHER'S NAME (First, Middle, Maiden Surname): **Lena Bell**
 19a. INFORMANT'S NAME (Type/Print): **ESTER HARMON**
 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): **CHICAGO, ILLINOIS**
 19c. Relationship: **NIECE**
 20a. METHOD OF DISPOSITION: Burial Cremation Removal from State Other (Specify):
 20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): **February 19, 1988**
Oak Hill Cemetery
 20c. LOCATION—City or Town, State: **Gary, Indiana**
 21a. SIGNATURE OF FUNERAL DIRECTOR: *Paul Anthony Robinson*
 21b. LICENSE NUMBER (of Licensee): **#1017284**
 22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: **ENNOLS & ROBINSON MEMORIAL CHAPEL 1900 W. 15th AV GARY, IN**
 23. To the best of my knowledge, death occurred at the time, date, and place stated.
 Signature and Title: *Mad Z...*
 23b. LICENSE NUMBER: **01034282**
 23c. DATE SIGNED (Month, Day, Year): **2/13/88**
 24. TIME OF DEATH: **2:00 a.m.**
 25. DATE PRONOUNCED DEAD (Month, Day, Year): **2-13-88**
 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): **No**
 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): **Cardiovascular Arrest**
 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.
Cerebral thrombosis with acute left hemisphere infarction, Pneumonia
 28a. WAS AN AUTOPSY PERFORMED? **NO**
 28b. IS THE AUTOPSY AVAILABLE FOR COMPLETION OF THIS CERTIFICATE OF DEATH? (Yes or no):
 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.
 29b. SIGNATURE AND TITLE OF CERTIFIER: *Dr. G. C. ...*
 29c. LICENSE NUMBER:
 29d. DATE SIGNED (Month, Day, Year): **2/13/88**
 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): **1400 S. LAKE PARK AVE APT. 905 Gary, IN 46342**
 31. HEALTH OFFICER'S SIGNATURE: *James T. Redick*
 32. DATE FILED (Month, Day, Year): **FEB 18 1988**
 33. MANNER OF DEATH:
 Natural Pending Investigation
 Accident Could not be Determined
 Suicide Homicide
 34a. DATE OF INJURY (Month, Day, Year):
 34b. TYPE OF INJURY:
 34c. INJURY AT WORK? (Yes or no):
 34d. DESCRIPTION OF HOW IT 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):

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40-10-
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FILED
APR 28 1 26 PM '88
LAKE COUNTY RECORD

LAKE COUNTY RECORD
APR 28 1 26 PM '88
RECORDED & INDEXED

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CITY OF GARY, IND.

James I. Hendrick, Jr.
CERTIFIED COPY
HEALTH COMMISSION
CITY OF GARY, IND.

DATE: FEB 18 1900