

INDIANA STATE BOARD OF HEALTH

Howard H Hill

Local No. 88-216... 997398

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME FIRST MIDDLE LAST 2 SEX 3 DATE OF DEATH (Mo Day Yr) Frank M. Elliott Male March 25, 1988

4 SOCIAL SECURITY NUMBER 5a AGE—Last Birthday 5b UNDER 1 YEAR 5c UNDER 1 DAY 6 DATE OF BIRTH (Month Day Year) 7 BIRTHPLACE (City and State or Foreign Country) 312-05-3433 72 8/30/1915 Indiana

8 YEAR LAST SERVED IN U.S. ARMED FORCES? 9a PLACE OF DEATH (Check only one. See instructions.) N/A HOSPITAL Inpatient Outpatient E.O.A. OTHER Nursing Home Residence Other (Specify)

9b FACILITY NAME (If not institution give street and number.) 9c CITY TOWN OR LOCATION OF DEATH 9d COUNTY OF DEATH 2100 Grant St. Gary Lake

10 MARITAL STATUS—Married Never Married Widowed 11 SURVIVING SPOUSE (If wife give maiden name) 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life) 12b KIND OF BUSINESS/INDUSTRY Married Erma Downs School Teacher Gary School Corp.

13a RESIDENCE—STATE IN 13b COUNTY Lake 13c CITY, TOWN OR LOCATION Gary 13d STREET AND NUMBER 2100 Grant St.

13e INSIDE CITY LIMITS? (Yes or no) 13f FARM 13g ZIP CODE 14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 15 RACE—American Indian, Black, White, etc. (Specify) 16 DECEDENT'S EDUCATION (Specify only highest grade completed) Yes No 46404 No No Black Elementary/Secondary (0-12) College (1-4 or 5+)

17 FATHER'S NAME (First Middle Last) 18 MOTHER'S NAME (First Middle, Maiden Surname) Harry Elliott Rose Moore

19a INFORMANT'S NAME (Type/Print) 19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c Relationship Erma Elliott 2100 Grant St. Gary, Lake, In, 46404 Wife

20a METHOD OF DISPOSITION 20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or 20c LOCATION—City or Town, State Burial Cremation Removal from State Donation Other (Specify) March 30, 1988 Oak Hill Cemetery GARY, IN

21a SIGNATURE OF FUNERAL DIRECTOR 21b LICENSE NUMBER (of Licensee) 22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors Inc. 2959 W. 11th Ave. #3007704 8700298

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title < 23b LICENSE NUMBER 23c DATE SIGNED (Month, Day, Year) 28410 SEP 14 2 00 PM '88

24 TIME OF DEATH M 25 DATE PRONOUNCED DEAD (Month, Day, Year) 26 WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or no)

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. Ruptured aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF) b. c. d.

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

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.

SIGNATURE AND TITLE OF CERTIFIER 28410 DATE SIGNED (Month, Day, Year) Nazzal Ahmad M.D. 28410 Auditor Lake County

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

31 HEALTH OFFICER'S SIGNATURE 32 DATE FILED (Month, Day, Year) James T. Hedrick M.D. MAR 31 1988

33 MANNER OF DEATH 34a DATE OF INJURY (Month, Day, Year) 34b TIME OF INJURY 34c INJURY AT WORK? (Yes or no) 34d DESCRIBE HOW INJURY OCCURRED Natural Pending Investigation Accident Suicide Could not be Determined Homicide 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)

FILED

SEP 13 1988

INDIANA A. BLASTICK
ROBERT LAKE COUNTY
CROWN POINT, INDIANA 46337

HW

HEALTH DEPARTMENT
James T. Rehrick, Jr.
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE MAR 31 1988