094996
Local No. 139

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST: J. MIDDLE: C. LAST: Lewis
2 SEX: Male
3 DATE OF DEATH (Month Day Year): May 29, 1989
4 SOCIAL SECURITY NUMBER: 424-40-1750
5a AGE—Last Birthday (Years): 59
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Month Day Year): Jul. 29, 1929
7 BIRTHPLACE (City and State or Foreign Country): Pittsview, Alabalma
8 YEAR LAST SERVED IN U.S. ARMED FORCES?: none
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): 4932 Alexander Avenue
9c CITY, TOWN OR LOCATION OF DEATH: East Chicago
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Betty Person
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machine Operator
12b KIND OF BUSINESS/INDUSTRY: Harbison Walker
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: East Chicago
13d STREET AND NUMBER: 4932 Alexander Ave.
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: No
13g ZIP CODE: 46312
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): 7th grade; College (1-4 or 5+):

PARENTS

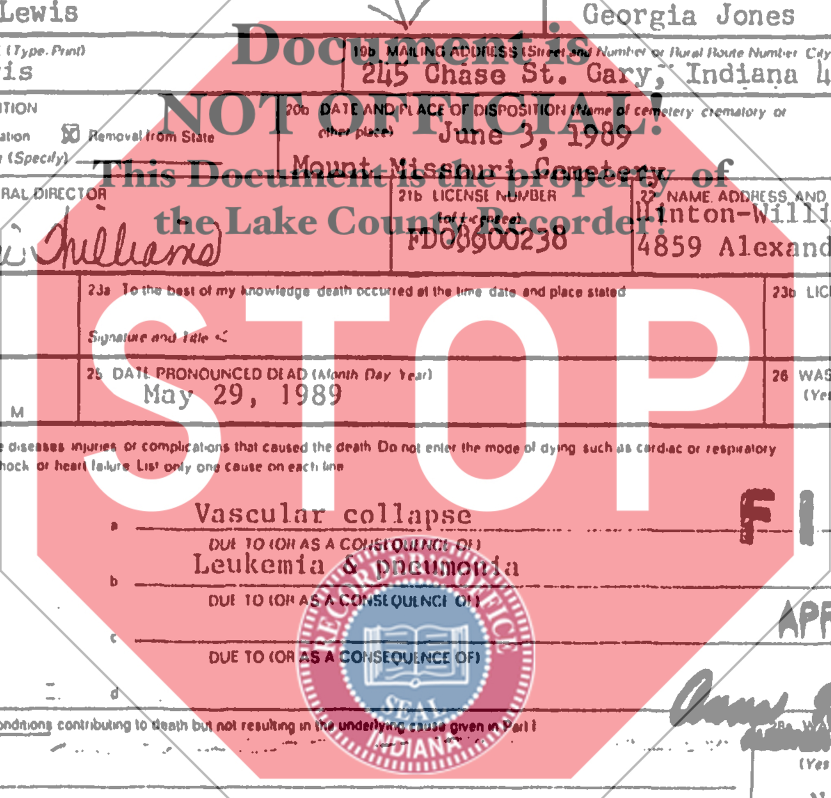
17 FATHER'S NAME (First, Middle, Last): Johnnie Lewis
18 MOTHER'S NAME (First, Middle, Maiden Surname): Georgia Jones

INFORMANT

19a INFORMANT'S NAME (Type/Print): Betty Lewis
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 245 Chase St. Gary, Indiana 46404
19c Relationship: Wife

DISPOSITION

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): June 3, 1989 Mount Missouri Cemetery
20c LOCATION—City or Town, State: Rutherford, Alabama
21a SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
21b LICENSE NUMBER (of Licensee): FD08600238
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams F.H. FH83001520 4859 Alexander, E.Chicago, IN 46312



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STOP

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
23b LICENSE NUMBER
23c DATE SIGNED (Month Day Year)

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

24 TIME OF DEATH: 6:54 P.M.
25 DATE PRONOUNCED DEAD (Month Day Year): May 29, 1989
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Vascular collapse — Approximate Interval Between Onset and Death: Unknown
DUE TO (OR AS A CONSEQUENCE OF):
b. Leukemia & pneumonia
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

FILED
APR 12 1990

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

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.

29b SIGNATURE AND TITLE OF CERTIFIER: Daniel D. Thomas
29c LICENSE NUMBER: 16120
29d DATE SIGNED (Month Day Year): May 30, 1989
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: E. A. Cassandra...
32 DATE FILED (Month Day Year): 5-31-89

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month Day Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED
000761
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# 44-234-8 Lot 9 & South 1/2 Lot 10 Block 19 Roxana (Subd.) Dog Lake Co 6th Subd.

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

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