INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 90-007 096459

State No.

T. Laurence Anderson 1109 Bidney Gary

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Zeola Wise	2. SEX: Female	3a. TIME OF DEATH: 9:30 p M	3b. DATE OF DEATH (Month Day Yr): January 3, 1990
4. SOCIAL SECURITY NUMBER: 173-20-5977	5a. AGE—Last Birthday (Years): 87	5b. UNDER 1 YEAR Months Days / 5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day Yr): Feb. 22, 1902
7. BIRTHPLACE (City and State or Foreign Country): Alpine, Alabama	8a. WAS DECEDENT A U.S. VETERAN?: No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: Never	9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center	9c. CITY, TOWN OR LOCATION OF DEATH: Gary	9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Widowed	11. SURVIVING SPOUSE (If wife, give maiden name): None	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: Homemaker
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN OR LOCATION: Gary	13d. STREET AND NUMBER: 944 Morton Street
13e. ZIP CODE: 46404	13f. INSIDE CITY LIMITS: ☐ No XX Yes; 13g. ON A FARM?: XX No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): XX No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify): Afro Amer.	17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):		

PARENTS

18. FATHER'S NAME (First, Middle, Last): Albert Swain	19. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Coles

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Lillian Lester	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1257 West 18th Ave., Gary, Indiana 46407	20c. Relationship: Sister

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jan. 9, 1990 Oakhill Cemetery	21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III	22b. EMBALMER'S LICENSE NO.: FDO 1016254	23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): FDO 1042607	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner, Inc. FDH300248 2295 Washington St., Gary, Ind. 46407

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms 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. Renal failure — Chronic
b. DUE TO (OR AS A CONSEQUENCE OF): Dehydration, malnutrition — Chronic
c. DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart failure
d. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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

FILED APR 20 1990

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No	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

CERTIFIER

29a. CERTIFIER (Check only one)
XX ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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) as stated.
☐ CORONER: 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 M. Anton — Lake County

29b. SIGNATURE AND TITLE OF CERTIFIER: G. Badar	29c. MEDICAL LICENSE NO.: 26783	29d. DATE SIGNED (Month, Day, Year): 1-4-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Gregorio Badar 5490 Broadway Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD MPH — 32. DATE FILED (Month, Day, Year): JAN. 8 1990

CORONER 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)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

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Gary Nta. N 20' Lt 15 Bl 30 All Lt 16 Bl 30 # 43-18216

SBH06-004 State Form 10110 (R2/3-89)

CERTIFIED BY:

Thelma E Foster M.D.

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE APR. 1 [illegible]