

Local No. 90-007

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. 7

095459

TYPE PRINT  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

CORONER  
USE ONLY

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, Year) 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 (Month, Day, Year) 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

9. PLACE OF DEATH (Check only one. See instructions)

HOSPITAL  Inpatient  ER/Outpatient  DDA

OTHER  Nursing Home  Other (Specify)  Residence

10. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center

11. CITY, TOWN OR LOCATION OF DEATH Gary

12. 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 or 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  Yes

13g. ON A FARM?  No  Yes

14. CITIZEN OF WHAT COUNTRY? U.S.A.

15. WAS DECEDENT OF HISPANIC ORIGIN?  No  Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

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 (13-16 or 17+) APR 73

18. FATHER'S NAME (First, Middle, Last) Albert Swain

19. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Coles

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

21a. METHOD OF DISPOSITION  Entombment  Burial  Cremation  Removal from State  Donation  Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Jan. 9, 1990 Oakhill Cemetery

21c. LOCATION (City or Town, Street) Gary, Indiana

22a. EMBALMERS NAME Sherman G. Banks III

22b. EMBALMERS LICENSE NO. FDO 1016254

23. WAS DEATH REPORTED TO CORONER?  No  Yes

24a. SIGNATURE OF FUNERAL DIRECTOR Edg. W.

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

26. PART I Enter the disease, 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

a. *Heart failure* *Chronic*

b. *Myocardial infarction as a consequence of* *cause of death - deterioration chronic*

c. *Coronary artery disease* *Heart failure*

*Chronic* *Heart disease*

26. PART II Other significant conditions contributing to death but not previously stated in Part I

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

29a. CERTIFIER (Check only one)  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.

29b. SIGNATURE AND TITLE OF CERTIFIER *L. J. Anderson*

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

31. HEALTH OFFICER'S SIGNATURE *William G. ...*

32. DATE FILED (Month, Day, Year) JAN. 8 1990

33. MANNER OF DEATH

Natural  Pending investigation

Accident  Could not be determined

Suicide  Homicide

34a. DATE OF INJURY (Month, Day, Year)

34b. TIME OF INJURY

34c. INJURY AT WORK? (Yes or no)

34d. DESCRIBE HOW INJURY OCCURRED

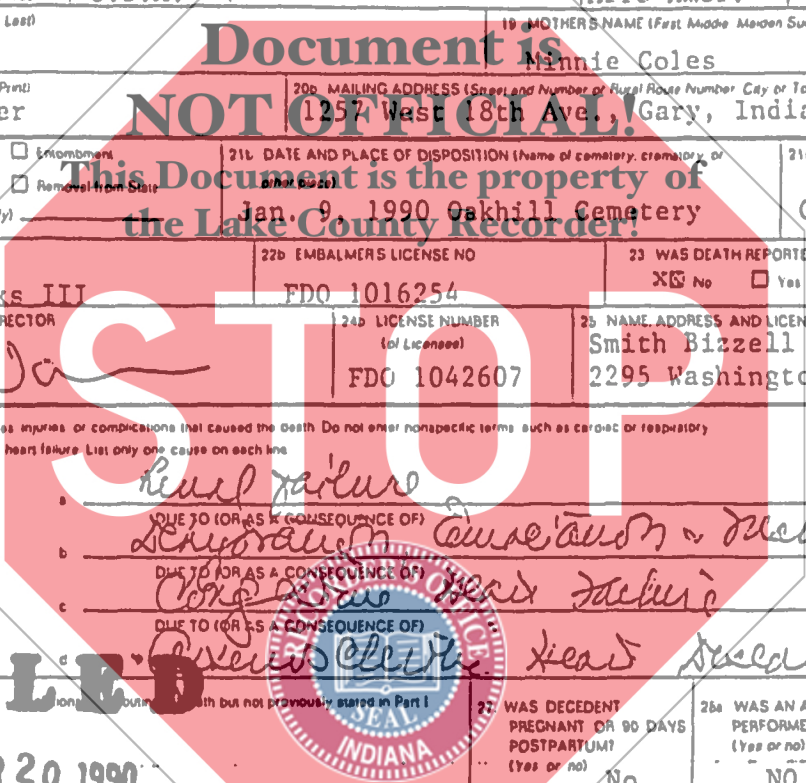
34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)

34f. LOCATION (Street and number or Rural Route Number, City or Town, State)

34g. DATE PRONOUNCED DEAD (Month, Day, Year)

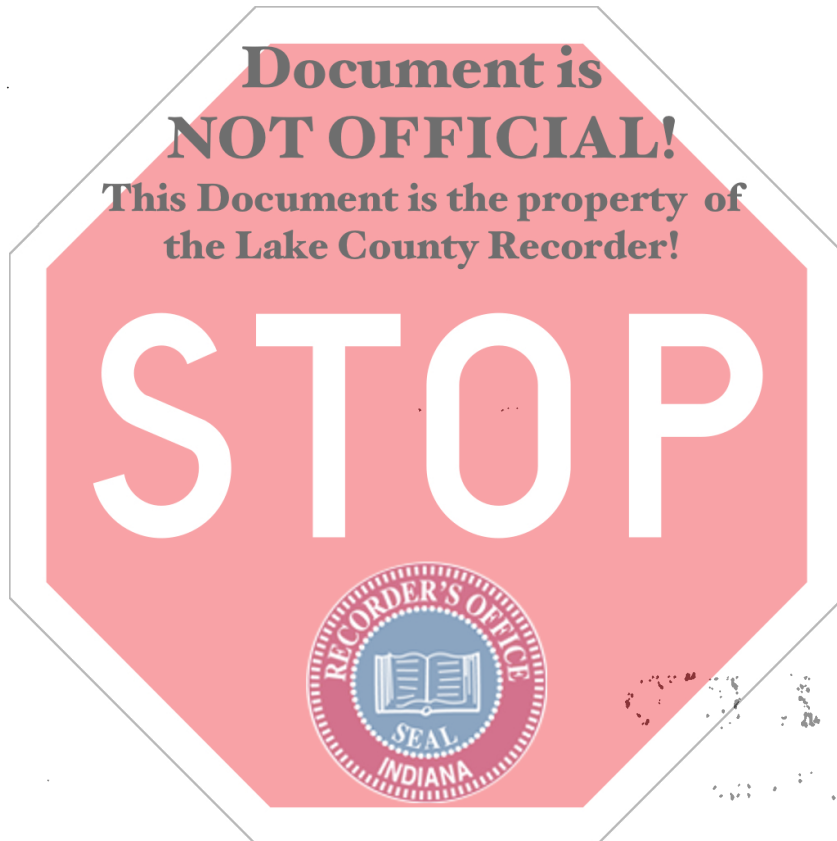
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

# 43-18216  
Gary, Ind. 720' St. 15 Bl. 30 All Rt. 16 Bl. 30



FILED  
APR 20 1990

000900 400



*[Faint, illegible handwritten notes or stamps]*

CERTIFIED BY:

*[Handwritten signature]*

HEALTH COMMISSIONER  
CITY OF GARY, IND.

APR 1 1980

DATE \_\_\_\_\_

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