3F 098078 SOA-81

Local No. .....

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Mary B. Emanuel	Female	2:30 p.m	December 9, 1989

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
	64			March 16, 1925	Jackson, Miss.

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See Instructions)
No	None	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Mary Medical Center Hobart	Hobart	Lake

10 MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Widow	None	Homemaker	Housewife

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	2345 Maryland Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46407	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	Black Amer.	12th. Grade	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Sample	Marie Crawford

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Bert Emanuel	2345 Maryland St., Gary, Ind. 46407	SON

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State	December 14, 1989/ Evergreen	Hobart, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
CELESTE P. KAUFMAN	FDE 1033626	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Celeste P. Kaufman	FDE: 1033626	KAUFMAN FUNERAL HOMES, INCORPORATED 421 West Fifth Avenue, Gary, IN 46402 FDH No: 3002411

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, 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.	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF) Metastasis to Lung	3 yrs 1 year
	c. DUE TO (OR AS A CONSEQUENCE OF)	

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

27. WAS DECEDENT PREGNANT OR 60 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a CERTIFIER (Check only one)

[X] 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
K. J. Sarmar, M.D.	01027669	01-03-90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Dr. Sarmar, 300 West 61 Ave., Lake Station, Indiana 46342 947-2505

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE — Charles Johnson

32 DATE FILED (Month, Day, Year) Jan 8, 1990

FILED

MAY 01 1990

AUDITOR LAKE COUNTY

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? (Yes or no)	If so, was decedent driver, passenger, pedestrian, etc

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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