William C. Jones, 1509 Chase St. Gary 46404

90-0196

Local No. 098926

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First Middle Last): Rose Marie Bates
- 2. SEX: Female
- 3a. TIME OF DEATH: 7:49 p M
- 3b. DATE OF DEATH (Month Day Yr): March 12, 1990
- 4. SOCIAL SECURITY NUMBER: 315-40-7866
- 5a. AGE—Last Birthday (Years): 53
- 5b. UNDER 1 YEAR: Months / Days
- 5c. UNDER 1 DAY: Hours / Minutes
- 6. DATE OF BIRTH (Mo. Day Yr): Nov. 19, 1936
- 7. BIRTHPLACE (City and State or Foreign Country): Brownsville, Tennessee
- 8a. WAS DECEDENT A US VETERAN?: No
- 8b. YEAR LAST SERVED IN US ARMED FORCES?: Never
- 9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
- 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): Married
- 11. SURVIVING SPOUSE (If wife, give maiden name): Robert Bates
- 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: 300 East Ridge Road
- 13e. ZIP CODE: 46409
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: XXX 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): 12; College (1-4 or 5+):

PARENTS

- 18. FATHER'S NAME (First Middle Last): R.V. Ballard Sr.
- 19. MOTHER'S NAME (First Middle Maiden Surname): Lucille Fouse

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Sylvia J. Hunter
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 W. 43rd Ave., Gary, Indiana 46408
- 20c. Relationship: Daughter

DISPOSITION

- 21a. METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Mar. 17, 1990 Evergreen Cemetery
- 21c. LOCATION—City or Town, State: Hobart, Indiana
- 22a. EMBALMER'S NAME: Sherman G. Banks III
- 22b. EMBALMER'S LICENSE NO.: FDO 1016254
- 23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
- 24b. LICENSE NUMBER (of Licensee): FDO 1042607
- 25. FUNERAL HOME: Smith ... Inc. FDH3002487, 229 Washington ... Gary, Ind. 46407

FILED MAY 4 1990

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.	Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF) b.	Diabetes Mellitus	
DUE TO (OR AS A CONSEQUENCE OF) c.		
d.		

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

PART II. Other significant conditions - 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

CERTIFIER

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: [signature]
- 29c. MEDICAL LICENSE NO.: 199936
- 29d. DATE SIGNED (Month, Day, Year): 3/13/90
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Oliver Crawford, M.D. 3290 Grant St., Gary, Indiana 46408

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: [signature]
- 32. DATE FILED (Month, Day, Year):

STATE OF INDIANA / S.S. NO. ... FILED FOR RECORD ... 17 PM 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.

#47-76 9 Lt 9 Blk 4 Ind. S. Cady Add.

366

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

CERTIFIED BY

HEALTH COMMISSION

CHICAGO, ILL.

DATE MAR 15 1990