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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 24-34-88 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: First Yvonne; Middle; Last Alexander
2 SEX: Female
3 DATE OF DEATH (Mo. Day, Yr.): November 16,1988
4 SOCIAL SECURITY NUMBER: 316-44-1868
5a AGE—Last Birthday (Years): 49
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Month Day Year): 8-2-1939
7 BIRTHPLACE (City and State or Foreign Country): Moscon,Mississippi
8 YEAR LAST SERVED IN U.S. ARMED FORCES? NO
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c CITY, TOWN OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced: Married(y)
11 SURVIVING SPOUSE (If wife, give maiden name): Robert Alexander
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life): Homemaker
12b KIND OF BUSINESS/INDUSTRY:
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 117 W. 35th Ave.
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: NO
13g ZIP CODE: 46407
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): 12; College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First, Middle, Last): Chalmers Donald
18 MOTHER'S NAME (First, Middle, Maiden Surname): Lula Horne

INFORMANT

19a INFORMANT'S NAME (Type/Print): Terri Deverthure Donald
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 W. 35th Ave. Gary, IN 46407
19c Relationship: Daughter

DISPOSITION

20a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 22, 1988 Evergreen Cemetery
20c LOCATION—City or Town, State: Hobart, Indiana
21a SIGNATURE OF FUNERAL DIRECTOR: Patricia Ives
21b LICENSE NUMBER (of Licensee): 8700298
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W. 11th Ave. Gary, IN 46404 #3007704

PRONOUNCING PHYSICIAN ONLY

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

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)
24 TIME OF DEATH: 6:25A M
25 DATE PRONOUNCED DEAD (Month Day Year): November 16, 1988
WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

CAUSE OF DEATH

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Respiratory arrest due to cancer
DUE TO (OR AS A CONSEQUENCE OF): b.
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

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:
Metastatic breast cancer
Gastric cancer

WAS AN AUTOPSY PERFORMED? (Yes or no): NO
WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

SEE INSTRUCTIONS

CERTIFIER

27 CERTIFIER (Check only one)

[X] 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

LAKE COUNTY HEALTH COMMISSIONER

28 SIGNATURE AND TITLE OF CERTIFIER: B Tara MD
29c LICENSE NUMBER: 01031667
29d DATE SIGNED (Month Day Year): 11/21/88

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type/Print): P. J. TARA, M.D. 8127 Merrillville Road, Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month Day Year): NOV 28 88

CORONER OR MEDICAL EXAMINER 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)

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP
RECORDER'S OFFICE STATE OF INDIANA
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HEALTH DEPT.
FILED
MAY 10 1990
ANN R. CATES
RECORDER LAKE COUNTY