Smith
1C

90-0366

INDIANA STATE BOARD OF HEALTH

Local No. 100946

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Albert W. Smith
2. SEX: Male
3a. TIME OF DEATH: 11:10A M
3b. DATE OF DEATH (Month Day Yr): May 5, 1990
4. SOCIAL SECURITY NUMBER: 316-09-3422
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR — Months / Days
5c. UNDER 1 DAY — Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): Dec. 3, 1920
7. BIRTHPLACE (City and State or Foreign Country): Alberdeen, Mississippi
8a. WAS DECEDENT A US VETERAN? Yes
8b. YEAR LAST SERVED IN US ARMED FORCES? 1945
8c. 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): 3660 Madison St.
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): Mary E. Carter
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Rigger (Retired)
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 3660 Madison St.
13e. ZIP CODE: 46408
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): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Otto Smith
19. MOTHER'S NAME (First Middle Maiden Surname): Ola Harris

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary E. Smith
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3660 Madison St. Gary, Indiana 46408
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 12, 1990 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana

22a. EMBALMER'S NAME: Tracy C. Williams
22b. EMBALMER'S LICENSE NO: FD08600238
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Chas Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home 83001520, 4859 Alexander Ave. East Chicago, In.

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. MYOCARDIAL INFARCTION — DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: b. CORONARY ARTERY DISEASE — DUE TO (OR AS A CONSEQUENCE OF); c. — DUE TO (OR AS A CONSEQUENCE OF); d.

15 YEARS

FILED
MAY 17 1990
AUDITOR LAKE COUNTY

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 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: M Gambetta
29c. MEDICAL LICENSE NO: 25594IN
29d. DATE SIGNED (Month, Day, Year): 05/09/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Miguel A. Gambetta, M.D. 4320 Fir Street Suite 410 East Chicago, IN 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Rebera E. Foster, MD MPH/sc
32. DATE FILED (Month, Day, Year): MAY 11 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): 400
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

1134

#46-338-20 Park Manor Add Lot 2