KEY 46-59-2+3
McKeys Add Lots 2+3
Block 4

10 C

102119

90-169

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. .... State No. ....

Richard E. [illegible] 519-N

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	Pierce Fort Jr.
2 SEX	Male
3a TIME OF DEATH	12:20p.m.
3b DATE OF DEATH (Month Day Yr)	February 19,1990
4 SOCIAL SECURITY NUMBER	259-01-4300
5a AGE—Last Birthday (Years)	81
5b UNDER 1 YEAR Months Days	
5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr)	11-26-1909
7 BIRTHPLACE (City and State or Foreign Country)	Tuskegee, Alabama
8a WAS DECEDENT A US VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	None
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number)	St. Mary Mediac 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)	Rebecca Ellison
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Carpenter
12b KIND OF BUSINESS/INDUSTRY	None
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Gary
13d STREET AND NUMBER	1520 Maryland Street
13e ZIP CODE	46407
13f INSIDE CITY LIMITS	☐ No [X] Yes
13g ON A FARM?	[X] No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	[X] No ☐ Yes
16 RACE—American Indian, Black, White etc (Specify)	Black Amer.
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	6th Grade

PARENTS

18 FATHER'S NAME (First Middle Last)	Pierce Fort Sr.
19 MOTHER'S NAME (First Middle Maiden Surname)	Mary Ann Johnson

INFORMANT

20a INFORMANT'S NAME (Type/Print)	Rebecca Fort
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1520 Maryland St., Gary, Ind. 46407
20c Relationship	Wife

DISPOSITION

21a METHOD OF DISPOSITION	[X] Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	2-24-1990 Fern Oaks
21c LOCATION—City or Town, State	Griffith, Indiana
22a EMBALMER'S NAME	CELESTE P. KAUFMAN
22b EMBALMER'S LICENSE NO.	FDE 1033626
23 WAS DEATH REPORTED TO CORONER?	[X] No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Celeste P. Kaufman (signature) Celeste P. Kaufman
24b LICENSE NUMBER (of Licensee)	FDE: 1033626
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	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, 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. Carcinoma Of The Left Lung with marked obstruction

DUE TO (OR AS A CONSEQUENCE OF)
b. Pleural Effusion

DUE TO (OR AS A CONSEQUENCE OF)
c.

DUE TO (OR AS A CONSEQUENCE OF)
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)

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

FILED
MAY 22 1990
(signature)

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: David Chube M.D. (signature)

29c. MEDICAL LICENSE NO.

29d DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. David Chube 1649 Broadway Gary, Indiana 882-0980

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE (signature)

32. DATE FILED (Month, Day, Year) MAR 5 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.

14.00

001388

ORIGINAL

MAR. 5 1990