SCC

PAT JOHNSON 2507 E. 22nd. AVE GARY 46407

89-0626

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

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

102799

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Elsie Mae Lyons	Female	8:33 A	September 14,1989

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)
492-32-0457	77			Sept.21,1911	Sardis, Mississippi

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
No	N/A	HOSPITAL: ☐ 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
2507 E. 22nd Avenue	Gary	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
Widowed	None	Seamstress	N/A

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	2507 E. 22nd Avenue

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+)
46404	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	Black	9 th	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
George Holcomb	Melinda

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Melinda N. Jimerson	2909 W. 18th Ave., Gary, IN 46404	Daughter

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	September 19,1989 Oak Hill Cemetery	Gary, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Patrician Owens	08700298	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Patricia Owens [signature]	08700298	Guy & Allen Funeral Dir. 8300704 2959 W. 11th Ave.,Gary,IN 46404

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	Vascular collapse	Unknown
DUE TO (OR AS A CONSEQUENCE OF) b	Due to arteriosclerotic heart & vascular disease	
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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No	

RECEIVED MAY 25 1990 STATE OF INDIANA FILED

Marshalltown Terrace L8 B14 Unit 25 Key #46-552-8

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Daniel D. Thomas [signature]	16120	Sept.18,1989

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

DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST.,C ROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
[signature]	SEP. 2 1 1989

CORONER USE ONLY

33. MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)

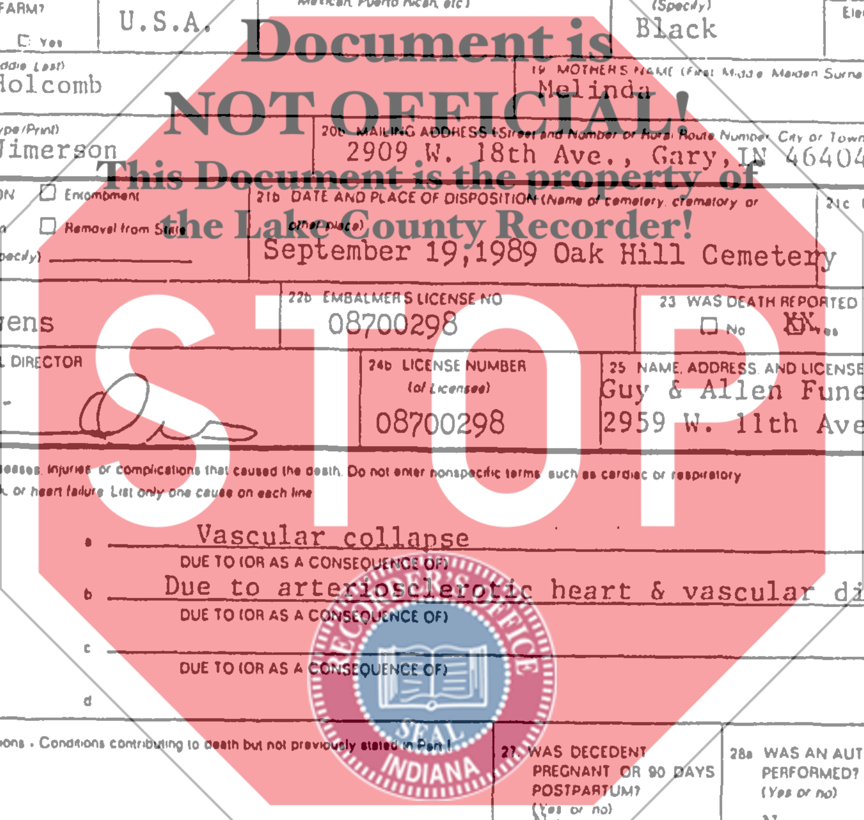
34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

FILED MAY 25 1990

[signature] AUDITOR LAKE COUNTY

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

001666 4.00



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CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE SEP 21 1989