

INDIANA STATE BOARD OF HEALTH

Local No.

247

138306

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

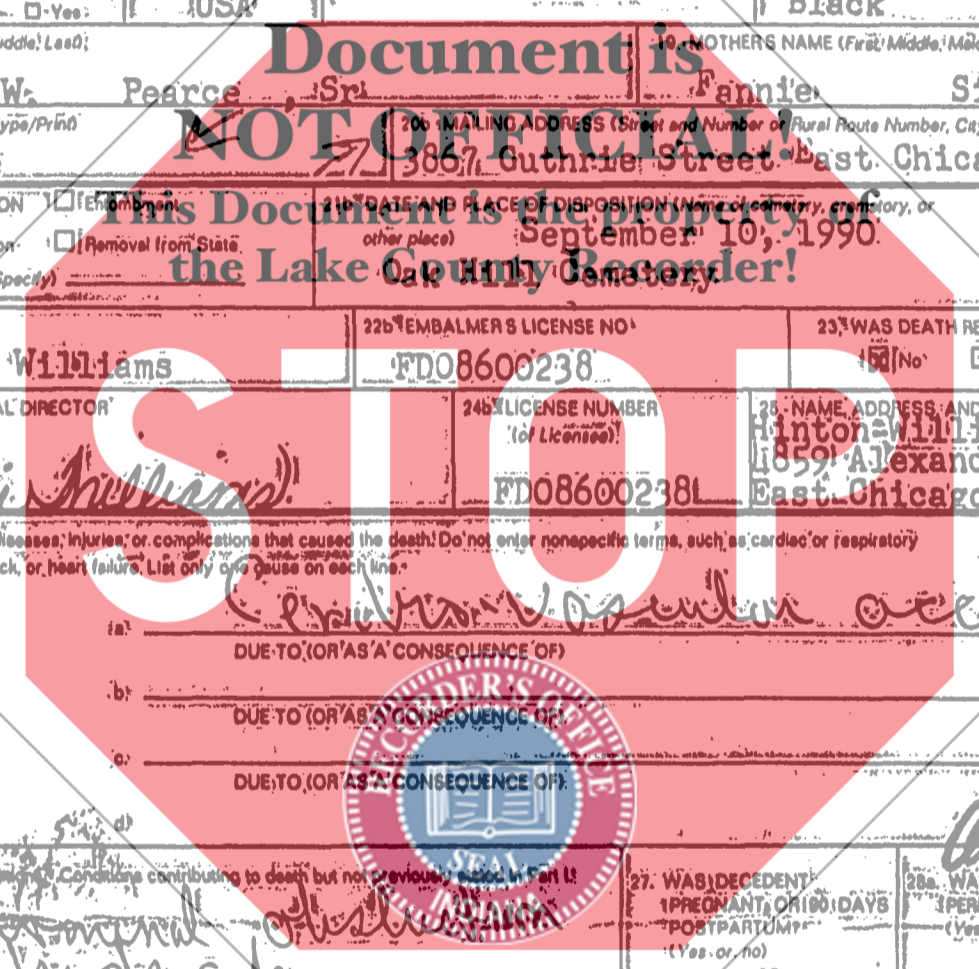
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First, Middle, Last) James Wesby Pearce Jr.		2 SEX Male	3a TIME OF DEATH 11:47p.m.	3b DATE OF DEATH (Month, Day, Yr) September 11, 1990
4 SOCIAL SECURITY NUMBER 312-09-7184	5a AGE—Last Birthday (Years) 82	5b UNDER 1 YEAR Months: Days	5c UNDER 1 DAY Hours: Minutes	6 DATE OF BIRTH (Mo, Day, Yr) March 22, 1908
7 BIRTHPLACE (City and State or Foreign Country) Savannah, Georgia	8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) St. Catherine Hospital		9c CITY, TOWN, OR LOCATION OF DEATH East Chicago	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Ladie Young	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Operator (retired)	12b KIND OF BUSINESS/INDUSTRY Inland Steel	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION East Chicago	13d STREET AND NUMBER 3867 Guthrie Street	
13e ZIP CODE 46312	14 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) Black
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <input checked="" type="checkbox"/> College (1-4 or 8+) 16th Grade		18 FATHER'S NAME (First, Middle, Last): James W. Pearce, Sr.		
19 MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Simpson		20a INFORMANT'S NAME (Type/Print) Ladie Pearce		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3867 Guthrie Street, East Chicago, In 46312		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) September 10, 1990, Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana
22a EMBALMER'S NAME Tracy Cheryl Williams		22b EMBALMER'S LICENSE NO. FD08600238		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheryl Williams</i>		24b LICENSE NUMBER (of license) FD08600238		24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Hinton-Williams Funeral Home, 4859 Alexander Avenue, East Chicago, In 46312, FH83001520
25 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. Chronic Vascular disease		25c APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DEC 7 1990		
25 PART II: Other significant conditions contributing to death but not previously stated in Part I. Dehydration		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)		29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>		29c MEDICAL LICENSE NO.		29d DATE SIGNED (Month, Day, Year)
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Edmund H. C. Browner, 2412 Oaklawn, East Chicago, Indiana				
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Tom Ranzkovich</i>				32 DATE FILED (Month, Day, Year) 9-7-90
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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.		



FILED

DEC 7 1990

Anna N. Antos

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Vertical text on the left margin: "Ladie Pearce, 11-20-90, 30-337-18"