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PLAINLY WITH  
UNFADING INK

THIS IS A  
PERMANENT  
RECORD

Below for State Office Use

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Disposition Permit Issued	/ /
Provisional Certificate	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

*And Oak Park add 51  
to 43, 44 + 45  
# 46-208-43449*

139893  
78-0805

# INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

State No. \_\_\_\_\_

Local No. \_\_\_\_\_

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED, IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

PARENTS

DISPOSITION

M.D. OR D.O.

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

EMBALMER'S NAME: Warner, Ede  
LICENSE No. 4260  
FUNERAL DIRECTOR'S SIGNATURE: *Warner*  
LICENSE No. 1984  
FUNERAL HOME: *Warner*  
LICENSE No. 248

1. DECEASED—NAME FIRST MIDDLE LAST <b>Benjamin L. Wesley</b>			SEX <b>male</b>	DATE OF DEATH (MO., DAY, YEAR) <b>Oct. 16, 1978</b>	
RACE—(e.g. White, Black, American Indian, etc.) (Specify) <b>Amer Blk</b>	AGE—Last Birthday (Yrs) <b>70</b>	UNDER 1 YEAR MO. DAYS	UNDER 1 DAY HOURS MINS	DATE OF BIRTH (Mo., Day, Yr.) <b>Sept. 3, 1908</b>	COUNTY OF DEATH <b>Lake</b>
7a. CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>		7c. HOSPITAL OR OTHER INSTITUTION—(Name if not in other, give street and number) <b>2713 Jefferson</b>			7d. IF HOSP. OR INST., Indicate DOA, OP, Emer. Rm., Inpatient (Specify) <b>N/A</b>
8a. STATE OF BIRTH (If not in U.S.A. name country) <b>Alabama</b>	8b. CITIZEN OF WHAT COUNTRY <b>USA</b>	9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	10. SURVIVING SPOUSE (If under give maiden name) <b>Luella Rendell</b>		11. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) <b>No</b>
11. SOCIAL SECURITY NUMBER <b>307-01-5372</b>		14a. USUAL OCCUPATION (Give kind of work done during most or working life, even if retired) <b>Retired</b>		14b. KIND OF BUSINESS OR INDUSTRY <b>Rockwell</b>	
15a. RESIDENCE—STATE <b>Indiana</b>		15b. COUNTY <b>Lake</b>		15c. CITY, TOWN OR LOCATION <b>Gary</b>	
15d. STREET AND NUMBER <b>2713 Jefferson</b>			15e. IS RESIDENCE ON A FARM? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		15f. INSIDE CITY LIMITS (SPECIFY YES OR NO) <b>yes</b>
16. IS DECEASED OF SPANISH DESCENT? (YES, SPECIFY MEXICAN, CUBAN, PORTO RICAN, ETC.) <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>					
16a. FATHER—NAME FIRST MIDDLE LAST <b>James Wesley</b>		16b. MOTHER—MAIDEN NAME FIRST MIDDLE LAST <b>Clara Smith</b>			
17a. INFORMANT—NAME (Type or print) <b>Luella Wesley</b>		17b. MAKING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP <b>2713 Jefferson St. Gary, In. 46407</b>			
18. BURIAL, CREMATION, REMOVAL, OTHER (Specify) <b>Burial</b>		18a. CEMETERY OR CREMATORY—FUNERAL HOME <b>Oakhill</b>		18b. LOCATION CITY OR TOWN STATE <b>Gary, In.</b>	
19a. DATE (MONTH, DAY, YEAR) <b>Oct. 20, 1978</b>		19b. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) <b>Smith Bizzell &amp; Warner Inc. 2295 Wash. St. Gary, In. 46408</b>		19c. STATE OF INDIANA <b>IN</b>	
20. To the best of my knowledge, death occurred at the time, date and place stated on the essential report 20a. (Signature) <i>[Signature]</i> <b>X</b>		20b. DATE SIGNED (Mo., Day, Yr.) <b>10-16-78</b>		20c. HOUR OF DEATH <b>10:00 AM</b>	
21a. NAME OF ATTENDING PHYSICIAN (Type or Print) <b>Dr. G. B. Mitchell</b>		21b. MAKING ADDRESS—PHYSICIAN <b>1706 Broadway Gary, In. 46407</b>			
22a. HEALTH OFFICER—SIGNATURE <i>[Signature]</i>				22b. DATE RECEIVED BY LOCAL HEALTH OFFICER <b>OCT 19 1978</b>	
23. IMMEDIATE CAUSE <b>Acute Myocardial Infarction</b>		23. IMMEDIATE CAUSE PER LINE FOR (a) AND (b) <b>Hypertensive Arteriosclerotic Heart Disease</b>		Interval between onset and death	
PART I (a) DUE TO, OR AS A CONSEQUENCE OF		PART I (b) DUE TO, OR AS A CONSEQUENCE OF		Interval between onset and death	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		AUTOPSY (Specify Yes or No) <b>No</b>	

SBH 06 003  
REV. 10/77

*Katz, Brennan + Angel  
7895 Sidway Ste R-S  
Mer 46410*

*m-7-600  
e*

00295



CERTIFIED BY

*Alvera E. Johnson*

HEALTH COMMISSIONER  
CITY OF GARY, IND.

DEC. 10 1995

DATE