Local No. 968-89

139896

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

LTIC 50661
LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Leroy P. Gregory
2. SEX: Male
3. DATE OF DEATH (Mo. Day Yr.): May 2, 1989
4. SOCIAL SECURITY NUMBER: 313-07-5792
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): 2-22-10
7. BIRTHPLACE (City and State or Foreign Country): STARKSVILLE, MISS
8. YEAR LAST SERVED IN US ARMED FORCES?: YES-WWII
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): MUNSTER MED INN
9c. CITY, TOWN OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): ANN MOORE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RETIRED
12b. KIND OF BUSINESS/INDUSTRY: US STEEL
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2428 Madison
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46407
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): BLACK
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): (2)

PARENTS

17. FATHER'S NAME (First, Middle, Last): WILLIAM GREGORY
18. MOTHER'S NAME (First, Middle, Maiden Surname): LIZZIE

INFORMANT

19a. INFORMANT'S NAME (Type/Print): ANN GREGORY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2428 MADISON ST. GARY, IND.
19c. Relationship: WIFE

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 6, 1989 FERN OAKS CEM.-GRIFFITH,IND.
20c. LOCATION—City or Town, State: Griffith, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): 01012357
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: ANDREW SMITH FUNERAL HOME 934 E. 21ST. AVE. 83002550

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: [signature]
23b. LICENSE NUMBER: IN 20248 / IN 20248
23c. DATE SIGNED (Month, Day, Year): May 2, 1989 / 5/2/89

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 12:15 PM / 12:15 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year): 5/2/89 May 2, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Recurrent Sepsis (Recurrent Sepsis)

DUE TO (OR AS A CONSEQUENCE OF):
b. Multiple Decubitus Ulcers (Multiple Decubitus Ulcers)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. General Debility (General Debility)

DUE TO (OR AS A CONSEQUENCE OF):
d. Alzheimer's Disease (Alzheimer's Disease)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPT. [date] 4 1989

[signature]
LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one):
[ ] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[X] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

FILED
DEC 28 1990
[signature]
AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: IN20248 / IN 20248
29d. DATE SIGNED (Month, Day, Year): May 2, 1989 / 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): W.V. Hehemann, MD 7905 Calumet Avenue, Munster, Indiana 46321 / WV Hehemann MD 7905 Calumet Munster IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): May 9, 1989

CORONER OR MEDICAL EXAMINER 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)

00776 6.00

Key #41-257-13 Dyer Park Lot 13 & S 2 of Lot 12

SBH08.004 State Form 10110 Rev. 10/87

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