10cc

601 Hanley St
Gary, IN 46406

New Brunswick Add
N 15 ft L.21 B11 + all L.22 B1.11
Key #46-78-22 unit #25

# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

Local No. P 2206-90

State No. 140557

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1. DECEASED—NAME (First, Middle, Last) | | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr) |
|---|---|---|---|---|
| Clarence | West | Male | 11:45P M | October 28, 1990 |

| 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) |
|---|---|---|---|---|---|
| 418-32-6136 | 61 | | | March 22, 1929 | Midway, Alabama |

| 8a. WAS DECEDENT A U.S. 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 |
|---|---|---|
| Methodist Hospital Southlake | Merrillville | 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 |
|---|---|---|---|
| Married | Tommie L. Cobb | Ladle Skull Operator | Valley Vulcan Mold |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Gary | 601 Hanley Street |

| 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) | |
|---|---|---|---|---|---|---|---|
| 46406 | ☐ No ☒ Yes | ☒ No ☐ Yes | USA | ☒ No ☐ Yes | Black | Elementary/Secondary (0-12): 8th | College (1-4 or 5+): |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Unknown | Lizzie West |

**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 |
|---|---|---|
| Tommie L. West | 601 Hanley Street Gary, Indiana 46406 | Wife |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | November 2, 1990 Evergreen Cemetery | Hobart, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Roosevelt Allen Sr. | 01051696 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| [signature] | [illegible] | 83007704 Guy & Allen Funeral Directors Inc 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. Use only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | | |
| Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last. | DUE TO (OR AS A CONSEQUENCE OF): | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

RECORDER'S OFFICE INDIANA

DEC 20 1990 FILED FOR RECORD

| PART II. Other significant conditions - Conditions contributing to death but not previously listed in Part I. | 27. WAS DECEDENT PREGNANT IN LAST 90 DAYS? (Yes or no) | 28. WAS AN AUTOPSY PERFORMED? (Yes or no) | 29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|---|
| | No | NO | |

**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) |
|---|---|---|
| [signature] | 01024744 | Nov. 3, 1990 |

**HEALTH OFFICER**

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

Dr. Brain Weiss 202 East 86th Pl. Merrillville, In. 46410

31. HEALTH OFFICER'S SIGNATURE [signature] — 32. DATE FILED (Month, Day, Year) November 3, 1990

**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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☒ Could not be Determined | | | | FILED |

| 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) |
|---|---|
| | DEC 26 1990 |

| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. |
|---|---|
| | [signature] AUDITOR LAKE COUNTY |

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

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