Local No. 341-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

91015495

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): ROOSEVELT BROWN
2 SEX: MALE
3a TIME OF DEATH: 5:30 A.M.
3b DATE OF DEATH (Month Day Yr): FEBRUARY 14, 1991
4 SOCIAL SECURITY NUMBER: 427-12-2703
5a AGE—Last Birthday (Years): 72
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr): May 7, 1918
7 BIRTHPLACE (City and State or Foreign Country): Sallis, Mississippi
8a WAS DECEDENT A U.S. VETERAN? Yes
8b YEAR LAST SERVED IN US ARMED FORCES? 1946
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number): THE COMMUNITY HOSPITAL
9c CITY TOWN OR LOCATION OF DEATH: MUNSTER
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Velma Thompson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pump Tender (retired)
12b KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: East Chicago
13d STREET AND NUMBER: 3831 Butternut Street
13e ZIP CODE: 46312
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc. (Specify): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Will Brown
19 MOTHER'S NAME (First Middle Maiden Surname): Rosie Ellis

INFORMANT

20a INFORMANT'S NAME (Type/Print): Velma Brown
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3831 Butternut St. East Chicago, In 46312
20c. Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 18, 1991 Ridgelawn Cemetery
21c LOCATION—City or Town, State: Griffith, Indiana
22a EMBALMER'S NAME: Tracy Cheri Williams
22b EMBALMER'S LICENSE NO: FD08600238
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b LICENSE NUMBER (of Licensee): FD08600238
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Hinton & Williams Funeral Home, 4859 Alexander Avenue, East Chicago, In 46312, FH83001520

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. congestive heart failure, end stage
DUE TO (OR AS A CONSEQUENCE OF): b. ventricular tachycardia, recurrent
DUE TO (OR AS A CONSEQUENCE OF): c. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF): d. cardiomyopathy

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 listed in Part I: Renal failure
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)

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: [signature]
29c MEDICAL LICENSE NO: 31576
29d DATE SIGNED (Month, Day, Year): FEBRUARY 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): WON-SHICK LOH M.D. 9134 COLUMBIA AVE. MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander Williams M.D.
32 DATE FILED (Month, Day, Year): February 15, 1991

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be determined ☐ 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 APR 5 1991

Anna N. Anton
AUDITOR LAKE COUNTY

00271 600

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

Key # 30-343-16 Ind Add. Ind. Harbor L.16 B2 11

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

STATE OF INDIANA S.S. NO. LAKE COUNTY FILED APR 3 2 20 ROBERT ... RECORDER