INDIANA STATE BOARD OF HEALTH

Local No. 89-0222 91016920

CERTIFICATE OF DEATH

State No. 46401

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: FIRST JIM; MIDDLE C.; LAST LOWE. | 2 SEX: MALE | 3 DATE OF DEATH (Mo., Day, Yr.): APRIL 2, 1989

4 SOCIAL SECURITY NUMBER: 304-12-6579 | 5a AGE—Last Birthday (Years): 83 | 5b UNDER 1 YEAR: Months, Days | 5c UNDER 1 DAY: Hours, Minutes | 6 DATE OF BIRTH (Month, Day, Year): 3-16-1906 | 7 BIRTHPLACE (City and State or Foreign Country): Opelaka, Alabama

8 YEAR LAST SERVED IN U.S. ARMED FORCES? None

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): Methodist Hosp. Northlake | 9c CITY, TOWN, OR LOCATION OF DEATH: Gary | 9d COUNTY OF DEATH: Lake

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced: Widowed | 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): Custodian | 12b KIND OF BUSINESS/INDUSTRY: Budd Plant

13a RESIDENCE—STATE: Indiana | 13b COUNTY: Lake | 13c CITY, TOWN, OR LOCATION: Gary | 13d STREET AND NUMBER: 700 E. 21st Ave

13e INSIDE CITY LIMITS (Yes or no): Yes | 13f FARM: No | 13g ZIP CODE: 46402 | 14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☐ No ☐ Yes Specify | 15 RACE—American Indian, Black, White, etc.: Black | 16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 1 yr

PARENTS

17 FATHER'S NAME (First, Middle, Last): William Lowe | 18 MOTHER'S NAME (First, Middle, Maiden Surname): Louwilla Lowe

INFORMANT

19a INFORMANT'S NAME (Type/Print): Dorathy Thomas | 19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1916 Grant Street | 19c Relationship: Daughter

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): April 8,1989 Burr Oak Cem | 20c LOCATION—City or Town, State: Hobart, Indiana

21a. SIGNATURE OF FUNERAL DIRECTOR: Paul Anthony Robinson | 21b. LICENSE NUMBER (of Licensee): 101-7284 | 22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Ennols & Robinson Memorial Cha 1900 W. 15th Ave Gary, IN 30024

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death | 22a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title | 23b. LICENSE NUMBER | 23c. DATE SIGNED (Month, Day, Year)

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

24. TIME OF DEATH: 8:55PM | 25. DATE PRONOUNCED DEAD (Month, Day, Year) | 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No)

FILED

APR 09 1991

AUDITOR LAKE COUNTY

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. Use only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Dysplasia DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. Renal failure DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.

Approximate Interval Between Onset and Death

CAUSE OF DEATH

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): no | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)

[X] 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.

☐ 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.

CERTIFIER

29b. SIGNATURE AND TITLE OF CERTIFIER: David E. Ross M.D. | 29c. LICENSE NUMBER: 01018989 | 29d. DATE SIGNED (Month, Day, Year): 4/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 1619 W. 5th Ave Gary David E. Ross M.D.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [illegible] M.D. | 32. DATE FILED (Month, Day, Year): April 11, 1989

CORONER OR MEDICAL EXAMINER 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 Ooccurred

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)

SBH06-004 State Form 10110 (R/10-87) DEATH/PD 1

9:8-A

CERTIFIED BY

HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE MAR. 22 1991