8 CC'S

Local No. 27-89

91018804

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. 220574-00

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST: ALICE MIDDLE: POLLIE LAST: ALLEN
2. SEX: FEMALE
3. DATE OF DEATH (Mo. Day Yr.): JANUARY 3, 1989
4. SOCIAL SECURITY NUMBER: 316-03-4813
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month Day Year): DEC. 2, 1919
7. BIRTHPLACE (City and State or Foreign Country): SALFORD, ENGLAND
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: HUSB. YES NO
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): ST. ANTHONY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CHARLES N, ALLEN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY: AT HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 4760 MONROE STREET
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46408
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. (Specify): WHITE
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): ALBERT EDWARD GOULDEN EVANS
18. MOTHER'S NAME (First, Middle, Maiden Surname): POLLIE BOOTH

INFORMANT

19a. INFORMANT'S NAME (Type/Print): CHARLES N. ALLEN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4760 MONROE STREET GARY, IN 46408
19c. Relationship: HUSBAND

DISPOSITION

20a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): N.W. IN CREMATION SERVICE JAN. 1989
20c. LOCATION—City or Town, State: CROWN POINT, IN
21a. SIGNATURE OF FUNERAL DIRECTOR: James F Burns
21b. LICENSE NUMBER (of Licensee): 1374
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH: 8600018 10101 BROADWAY CROWN POINT, IN 46307

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
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

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

24. TIME OF DEATH: 5:13 P. M
25. DATE PRONOUNCED DEAD (Month, Day, Year): JANUARY 3, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Ventricular Fibrillation
DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF): Generalized Arteriosclerosis
DUE TO (OR AS A CONSEQUENCE OF): Diabetes mellitus

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

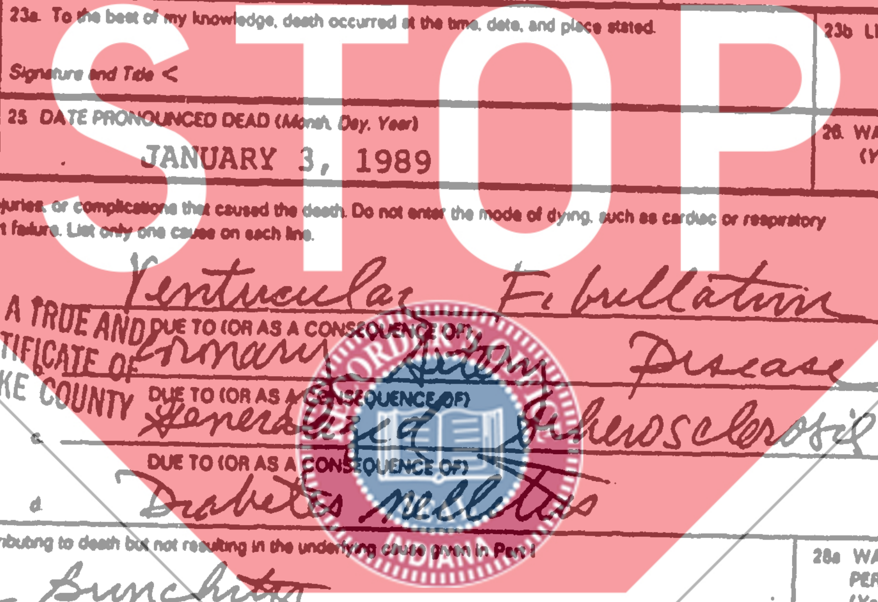
Approximate Interval Between Onset and Death

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

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

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

LAKE COUNTY HEALTH COMMISSIONER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STOP

FILED APR 19 1991
Anna N. Anton
AUDITOR LAKE COUNTY

CERTIFIER

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.
☐ 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: William J Pierce MD
29c. LICENSE NUMBER: 25010
29d. DATE SIGNED (Month, Day, Year): 1/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DR. WILLIAM PIERCE, M.D. 8683 CONNECTICUT MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): 1-6-89

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 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)

Key # 45-170-27 Lindale Sub. L24 B1.6

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SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1

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