PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS DOCUMENT NOT VALID UNLESS STAMPED ON REVERSE SIDE

Georgia F. Meeks
P.O. Box M-522
Gary 46401

91022018

1. DECEASED—NAME (First, Middle, Last): Eddie Hillard Meeks
2. SEX: Male
3a. TIME OF DEATH: 9:43 a.m.
3b. DATE OF DEATH (Month, Day, Yr): January 6,1991
4. SOCIAL SECURITY NUMBER: 426-40-4649
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): May 3,1911
7. BIRTHPLACE (City and State or Foreign Country): Bolivar, MS.
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): Porter Memorial Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Georgia Frances Boner
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machine Operator
12b. KIND OF BUSINESS/INDUSTRY: Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 921 W. 26th Ave.
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS?: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 8th; College (1-4 or 5+):
18. FATHER'S NAME (First, Middle, Last): Hilliard Meeks
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Henry
20a. INFORMANT'S NAME (Type/Print): Georgia Frances Meeks
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 921 W. 26th Ave. Gary,IN. 46407
20c. Relationship: Wife
21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 12,1991 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary,IN.
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO.: 01051701
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W.11th Ave.Gary, In.46404 — 083007704

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Myocardial Infarction — MYCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
b. Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Renal Failure, COPD

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):

29a. CERTIFIER (Check only one):
[X] 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: JOHN L. SWARNER JR., M.D. INC.
29c. MEDICAL LICENSE NO.: #24990
29d. DATE SIGNED (Month, Day, Year): February 4, 1991
30. NAME AND ADDRESS OF PHYSICIAN WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 2101 EAST GLENDALE BOULEVARD VALPARAISO, INDIANA 46383
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): February 12,1991
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 (Mo, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Specify driver, passenger, etc.)

FILED
MAY 09 1991
[signature]
AUDITOR LAKE COUNTY

00558

ROBERT ... RECORDER
MAY 9 ... PM
STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED FOR RECORD

Key #43441-20 Garfield Park - L-20 X L-21 - Bl 2

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