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91022898

Calumet Nat'l Bk
Cleveland off
1975 W Ridge Rd

# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

No. ...................

State No. ..Gary 46408....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST LAVERNE MIDDLE CECIL LAST CAMPBELL
2. SEX MALE
3. DATE OF DEATH (Mo. Day Yr.) JUNE 1, 1989
4. SOCIAL SECURITY NUMBER 313126963
5a. AGE—Last Birthday (Years) 66
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Month, Day, Year) 4/22
7. BIRTHPLACE (City and State or Foreign Country) GARY, IN
8. YEAR LAST SERVED IN U.S. ARMED FORCES? 1943
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) METHODIST HOSPITAL NORTHLAKE
9c. CITY, TOWN, OR LOCATION OF DEATH GARY
9d. COUNTY OF DEATH LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name) MYRTLE L. GATLIN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) POSTAL CARRIER
12b. KIND OF BUSINESS/INDUSTRY U.S. POSTAL SERVICE
13a. RESIDENCE—STATE INDIANA
13b. COUNTY LAKE
13c. CITY, TOWN, OR LOCATION GARY
13d. STREET AND NUMBER 1590 HENDRICKS
13e. INSIDE CITY LIMITS? (Yes or no) YES
13f. FARM NO
13g. ZIP CODE 46404
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) BLACK
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3Years

PARENTS

17. FATHER'S NAME (First, Middle, Last) CECIL LAVERNE CAMPBELL
18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE GREENWOOD

INFORMANT

19a. INFORMANT'S NAME (Type/Print) MYRTLE L. CAMPBELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1590 HENDRICKS STREET, GARY, IN 46404
19c. Relationship WIFE

DISPOSITION

20a. METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) June 9,1989 Evergreen Cemetery
20c. LOCATION—City or Town, State Hobart, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR Valerie X Broadnax
21b. LICENSE NUMBER (of Licensee) 46
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen, 2959 W. 11th Ave., 83007704

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 4:45 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year) June 1, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) NO

CAUSE OF DEATH

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. MASSIVE INTRACEREBRAL HEMMORRHAGE

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) b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.

FILED MAY 14 1991 Oscar N. Arlene AUDITOR LAKE COUNTY

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)

STATE OF INDIANA S.S. NO. LAKE FILED MAY 15 9 17 AM '91 ROBERT FREELAND RECORDER

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 Odies H. Williams III MD
29c. LICENSE NUMBER 01026836
29d. DATE SIGNED (Month, Day, Year) 6-8-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) ODIES H. WILLIAMS III, M.D. 2200 GRANT STREET GARY, INDIANA 46404

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year) JUN 14 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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)

00235

#41-460-13 Winters & Powers Add. All Lt 15 Bl 1

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

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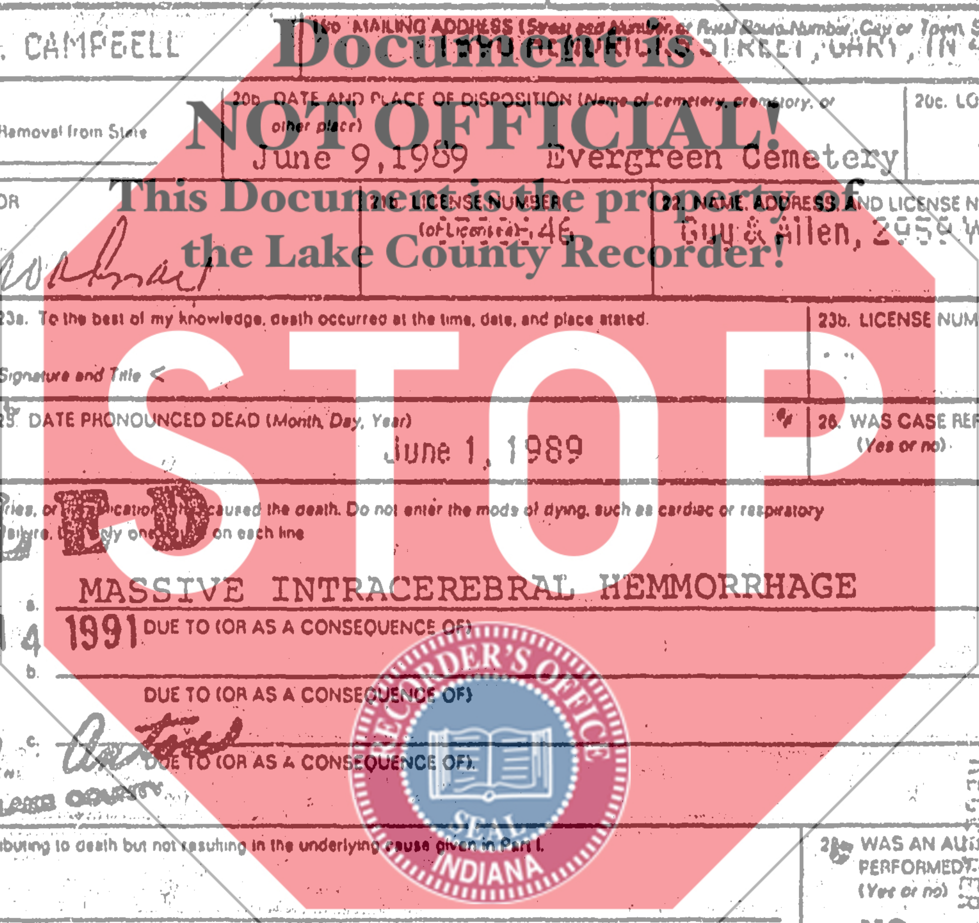

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE JUN 14 1989