Local No. 307

91023743

# INDIANA STATE BOARD OF HEALTH
## CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
APR 30,1991 Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): James L. Lewis
2 SEX: Male
3a TIME OF DEATH: 4:35 p.M
3b DATE OF DEATH (Month Day Yr): April 23, 1991
4 SOCIAL SECURITY NUMBER: 422-38-2992
5a AGE—Last Birthday (Years): 58
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo, Day, Yr): May 15,1932
7 BIRTHPLACE (City and State or Foreign Country): Barbara County,AL.
8a WAS DECEDENT A US VETERAN? NO
8b YEAR LAST SERVED IN US ARMED FORCES? N/A
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Margaret's Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Divorced
11 SURVIVING SPOUSE (If wife, give maiden name): None
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Electrician
12b KIND OF BUSINESS/INDUSTRY: Lewis/Electric
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 2101 Porter Street
13e ZIP CODE: 46406
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? XX 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) College (1-4 or 5+): Unknown

PARENTS

18 FATHERS NAME (First Middle, Last): June Lewis
19 MOTHERS NAME (First, Middle, Maiden Surname): Bertha Richardson

INFORMANT

20a INFORMANT'S NAME (Type/Print): Cowena Lewis
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2101 Porter Street Gary,Indiana 46406
20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Other (Specify) ☒ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 26,1991 LOCAL
21c LOCATION—City or Town, State: Hurtsburo,Alabama
22a EMBALMERS NAME: Roosevelt Allen Sr.
22b EMBALMER'S LICENSE NO: 01051696
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 08700298
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors,Inc. 2959 W.11th Ave. Gary,IN 46404

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 Squamous cell carcinoma pleura | 5 months |
| Conditions, if any which gave rise to the immediate cause, stating the underlying cause last | b DUE TO (OR AS A CONSEQUENCE OF) | |
| | c DUE TO (OR AS A CONSEQUENCE OF) | |
| | d DUE TO (OR AS A CONSEQUENCE OF) | |

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I
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: John Lanman MD
29c MEDICAL LICENSE NO.: 18203
29d DATE SIGNED (Month, Day, Year): April 4/24/91
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Lanman, M.D. 716 Seberger Dr., Munster,Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month, Day, Year): APR 30 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, ...

FILED MAY 17 1991 — RECORDER LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED — ROBERT ... RECORDER — MAY 17 ... 2 ...

SBH06-004 State Form 10110 (R2/...) DEA CERT/PD 1

01115

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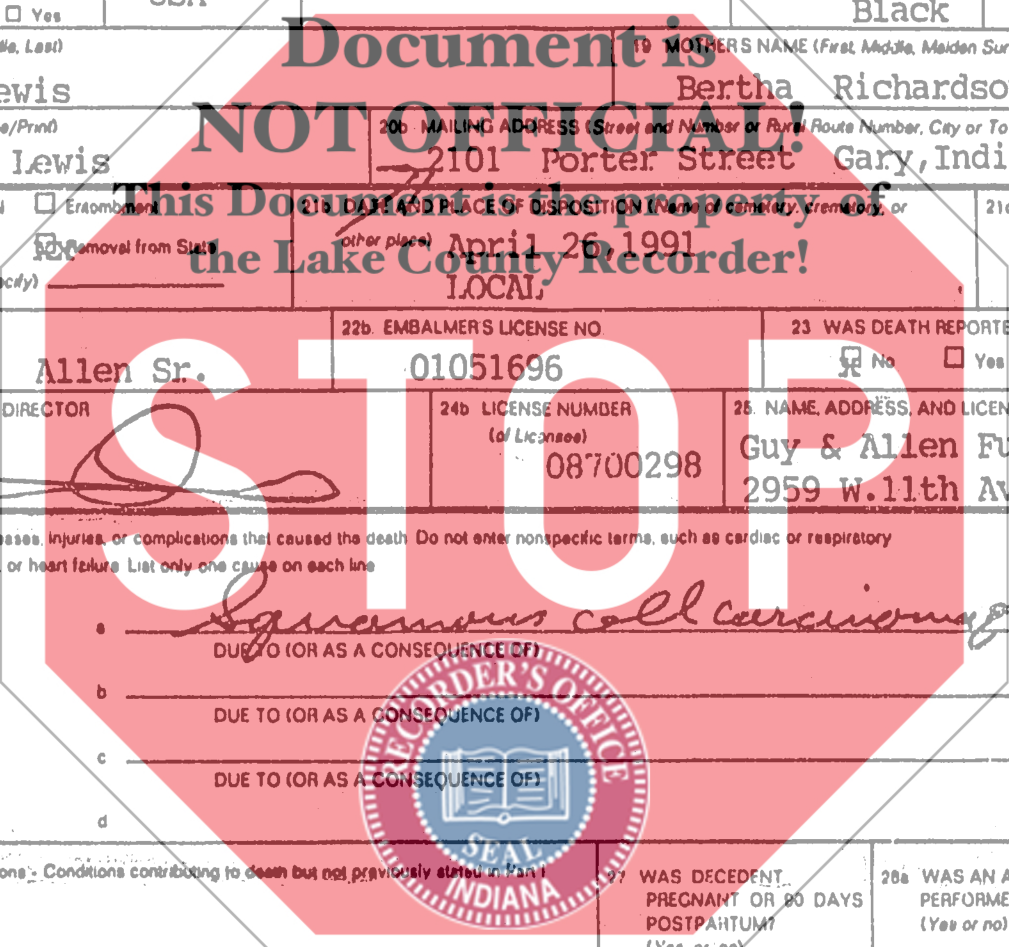
49-489-24 W. JOHN BORAK UB LOT 24 IN 25FT OF LOT 23 BL1

Moselle Lewis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