Local No. 0288-91 91023830

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JESSIE M. RANDLE
2. SEX: FEMALE
3a. TIME OF DEATH: M
3b. DATE OF DEATH (Month, Day, Yr): April 3, 1991
4. SOCIAL SECURITY NUMBER: 340101688
5a. AGE—Last Birthday (Years): 87
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 19, 1903
7. BIRTHPLACE (City and State or Foreign Country): MISSOURI
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): METHODIST HOSPITAL SOUTHLAKE
9c. CITY, TOWN, OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): PAUL RANDLE
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: Domestic
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 4525 W. 25TH AVEUE
13e. ZIP CODE: 46404
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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JESSE MIZNER
19. MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA GARP

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CATHERINE BOWMAN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4525 W. 25TH AVENUE, GARY, IN 46404
20c. Relationship: DAUGHTER

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): APRIL 6, 1991 OAK HILL CREMATORY
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, 2959 W. 11th Ave., 83007704 Gary, Indiana 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. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF)
b. Coronary heart disease
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

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

APR 11 1991

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Hypertensive heart disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

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: [signature] Dr. Billena
29c. MEDICAL LICENSE NO.: 1026067
29d. DATE SIGNED (Month, Day, Year): 4-6-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 5490 Broadway Plaza, Merrillville, In: 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): April 11, 1991

FILED MAY 17 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, passenger, pedestrian, etc.

Auditor Lake County 00734 600 E

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Katz, Brennan + Angel 7895 Bwy Merr 46410

49-445-17 2nd Add Oak Meadow Lt 16