

91-0000

INDIANA STATE BOARD OF HEALTH

Jackie L. Shropshire
4860 Bdway
Gary, IN 46408
State No.

Local No. 91028331

CERTIFICATE OF DEATH

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) ARTHUR F. SIMMONS				2. SEX MALE		3a. TIME OF DEATH 8 P M		3b. DATE OF DEATH (Month, Day, Yr) JANUARY 30, 1991	
4. SOCIAL SECURITY NUMBER 306-09-2126		5a. AGE—Last Birthday (Years) 93	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) JUNE 6, 1897		7. BIRTHPLACE (City and State or Foreign Country) GREENVILLE, ALABAMA		
8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			9b. OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
8b. 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 (Specify) WIDOWER		11. SURVIVING SPOUSE (If wife, give maiden name)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) LABORER			12b. KIND OF BUSINESS/INDUSTRY U.S. STEEL		
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION GARY			13d. STREET AND NUMBER 3137 W. 21st. AVE.		
13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) BLK.		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th. College (11-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last) EMMANUEL SIMMONS				19. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ELIZABETH SILVER					
20a. INFORMANT'S NAME (Type/Print) MARY REEVES				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 3137 W. 21st. AVE. GARY, IND. 46404			20c. Relationship DAUGHTER		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) EVERGREEN MEMORIAL FEBRUARY 6, 1991			21c. LOCATION—City or Town, State HOBART, INDIANA			
22a. EMBALMER'S NAME JOHN V. HOWER			22b. EMBALMER'S LICENSE NO. 8600440		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Violet E. Hower</i>			24b. LICENSE NUMBER (of Licensee) 1014618		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME HOWER FUNERAL HOME 300251 RD. 1628 WASHINGTON ST. GARY, IND.				
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. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): CHRONIC RENAL FAILURE DEHYDRATION JUN 06 1991									
26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <input checked="" type="checkbox"/> INDIANA									
27. WAS DECEDENT PREGNANT, OR 90 DAYS POSTPARTUM? (Yes or no) NO			28. WAS AN AUTOPSY PERFORMED? (Yes or no) NO			29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>William H. Williams III, M.D.</i>						29c. MEDICAL LICENSE NO. 01026836		29d. DATE SIGNED (Month, Day, Year) 2/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) XODIES H. WILLIAMS III, M.D. 2200 GRANT ST. GARY, INDIANA 46404									
31. HEALTH OFFICER'S SIGNATURE <i>John Williams</i>							32. DATE FILED (Month, Day, Year) FEB. 05 1991		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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)						
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 00093						

DECEDENT

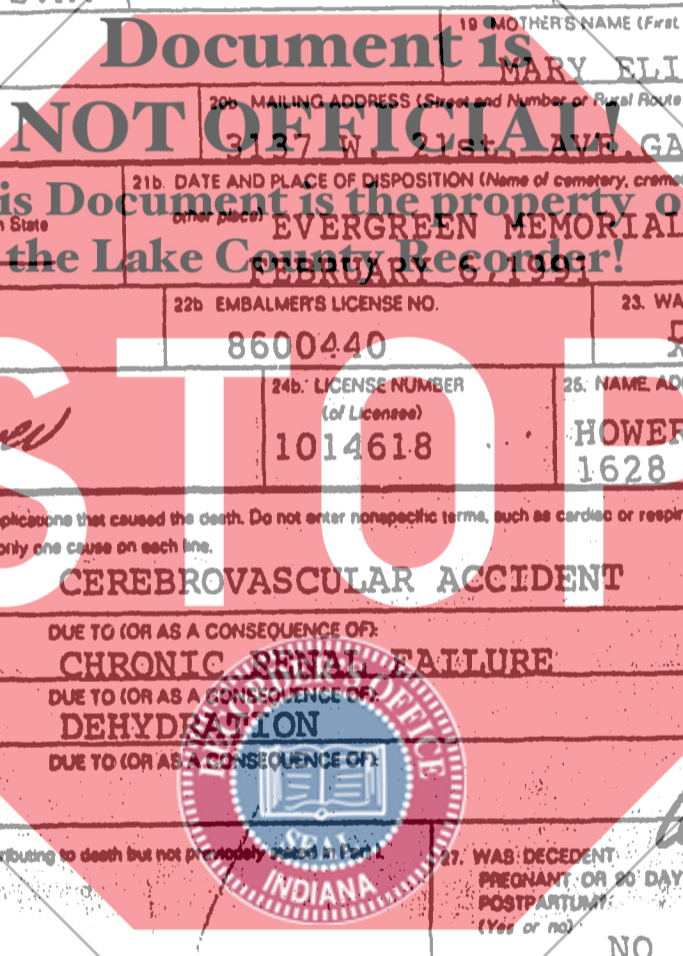
PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CORONER USE ONLY



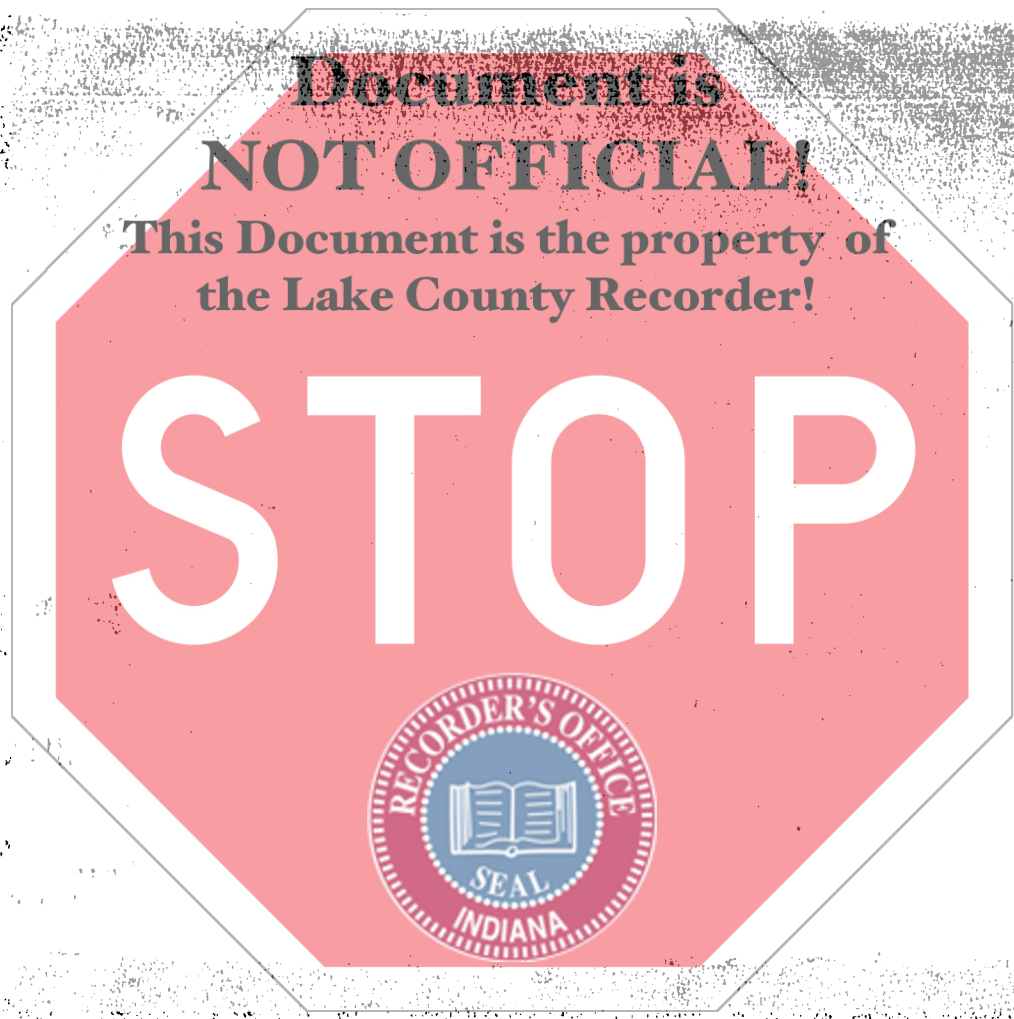
FILED

JUN 06 1991

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10-12
6-11-11

11-11-11



011100

CERTIFIED BY
Julia E. ...
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE FEB. 05 1991