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91032361

INDIANA STATE BOARD OF HEALTH

Atty John Hall
1937 Madison
Gary, In 46407

Local No. 910242

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Ella Mae Covington				2 SEX Female		3a TIME OF DEATH 01:05P M		3b DATE OF DEATH (Month, Day, Yr) March 19, 1991					
4 SOCIAL SECURITY NUMBER 311-44-8164		5a AGE—Last Birthday (Years) 83		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) APR 4, 1907		7 BIRTHPLACE (City and State or Foreign Country) Talahassee, Mississippi			
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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence									
9b FACILITY NAME (If not institution, give street and number) St. Mary Medical Center						9c CITY, TOWN, OR LOCATION OF DEATH Gary			9d COUNTY OF DEATH Lake				
10 MARITAL STATUS Widowed		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) House Wife			12b KIND OF BUSINESS/INDUSTRY Own Home					
13a RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary			13d. STREET AND NUMBER 2369 Buchanan Street						
13a. ZIP CODE 46407		13i. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13j. ON A FARM? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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) Afro Am		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6 College (1-4 or 5+)	
18 FATHER'S NAME (First, Middle, Last) James Bradley						19 MOTHER'S NAME (First, Middle, Maiden Surname) Ella Demyers							
20a INFORMANT'S NAME (Type/Print) Ellastine May				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2670 Polk Street, Gary, Indiana 46407				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) Oakhill Cemetery				21c LOCATION—City or Town, State Gary, Indiana 46408					
22a EMBALMERS NAME Sherman G. Banks				22b. EMBALMER'S LICENSE NO. FDE1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ede Wa</i>				24b. LICENSE NUMBER (of Licensee) FDO1042607		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FDH3002487 Smith Bizzell & Warner 2295 Washington St. Gary, In. 46407							
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. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF) b. Sepsis DUE TO (OR AS A CONSEQUENCE OF) c. renal failure DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last													
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) 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>Venkatrama Garlapati</i>						29c. MEDICAL LICENSE NO. 01030560			29d. DATE SIGNED (Month, Day, Year) 3.21.91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Venkatrama Garlapati, 6111 Harrison Street, Merrillville, Indiana 46410													
31. HEALTH OFFICER'S SIGNATURE <i>Venkatrama Garlapati</i>									32. DATE FILED (Month, Day, Year) MAR. 21 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"/> Could not be Determined <input type="checkbox"/> Homicide			34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED				
CORONER USE ONLY			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) JUN 20 1991							
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) No <i>Venkatrama Garlapati</i> AUDITOR LAKE COUNTY									

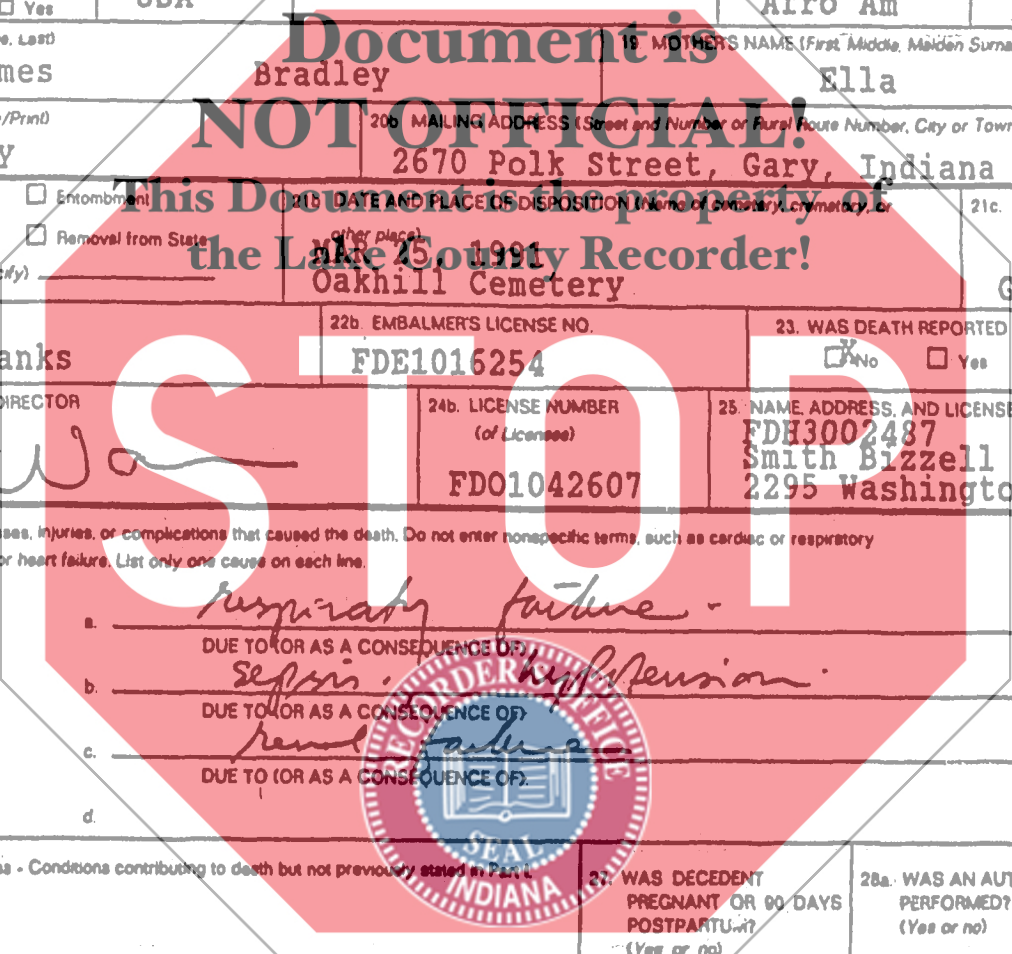
KEY 43-222-300
GARY PARK & OT
30 BUCK 3

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH



ROBERT (BOB) FR...
RECORDER
JUN 28
10 35 AM
DATE OF INDIANA'S S.N.D.
FILED FOR RECORD
LAKE COUNTY

FILED

JUN 20 1991

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CERTIFIED BY:

Shirley E. Johnson

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE MAR 21 1989