

91043851

INDIANA STATE BOARD OF HEALTH

cal No. 910180

CERTIFICATE OF DEATH

State No.

50

DECLASSED—NAME (First Middle Last) **Geraldine Carr** SEX **Female** TIME OF DEATH **08:45P** DATE OF DEATH (Month, Day, Year) **March 1, 1991**

SOCIAL SECURITY NUMBER **308-28-8813** AGE—Last Birthday (Years) **61** SEX UNDER 1 YEAR **None** SEX UNDER 1 DAY **None** DATE OF BIRTH (Mo, Day, Yr) **JUN 26, 1929** BIRTHPLACE (City and State or Foreign Country) **Gary, Indiana**

WAS DECEDENT A US VETERAN? **No** YEAR LAST SERVED IN US ARMED FORCES? **N/A** PLACE OF DEATH (Check only one. See instructions.)  
 HOSPITAL:  Inpatient  Outpatient  DCA OTHER:  Nursing Home  Other (Specify)  Residence

FACILITY NAME (If not institution give street and number) **Methodist Northlake** CITY/TOWN OR LOCATION OF DEATH **Gary** COUNTY OF DEATH **Lake**

MARITAL STATUS **Married** SURVIVING SPOUSE (If wife give maiden name) **Arrelen Carr** DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **house wife** KIND OF BUSINESS/INDUSTRY **Own home**

RESIDENCE—STATE **Indiana** COUNTY **Lake** CITY/TOWN OR LOCATION **Gary** STREET AND NUMBER **2572 Washington**

ZIP CODE **46407** INSIDE CITY LIMITS  No  Yes ON A FARM?  No  Yes CITIZEN OF WHAT COUNTRY? **USA** WAS DECEDENT OF HISPANIC ORIGIN?  No  Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) RACE—American Indian, Black, White, etc (Specify) **Afro Am** DECEDENT'S EDUCATION (Specify only highest grade completed) **12-** (Elementary/Secondary (0-12) College (1-4 or 5+))

FATHER'S NAME (First Middle Last) **Napoleon Golden** MOTHER'S NAME (First Middle Maiden Surname) **Cora Adams**

INFORMANT'S NAME (Type/Print) **Arrelen Carr** MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **2572 Washington Street, Gary, Indiana 46407** Relationship **Husband**

METHOD OF DISPOSITION  Burial  Cremation  Removal from State  Donation  Other (Specify) DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **1991 Oakhill Cemetery** LOCATION—City or Town, State **Gary, Indiana 46408**

EMBALMERS NAME **Sherman G. Banks** EMBALMERS LICENSE NO **FDE1016254** WAS DEATH REPORTED TO CORONER?  No  Yes

SIGNATURE OF FUNERAL DIRECTOR **[Signature]** LICENSE NUMBER (of Licensee) **FDO1042607** NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME **FDH3002487 Smith Bizzell & Warner 2295 Washington St. Gary, In. 46407**

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) **Acute Respiratory Arrest** Appropriate Interval Between Onset and Death **28**

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

a. **Bilateral Pneumonia** (DUE TO (OR AS A CONSEQUENCE OF))  
 b. **Cerebrovascular Accident** (DUE TO (OR AS A CONSEQUENCE OF))  
 c. **Arteriosclerotic, Cardiovascular Disease** (DUE TO (OR AS A CONSEQUENCE OF))

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.  
**Diabetes Mellitus, Bilateral Amputee, Anemia**

WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) **No** WAS AN AUTOPSY PERFORMED? (Yes or no) **No** WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) **No**

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.

SIGNATURE AND TITLE OF CERTIFIER **[Signature]** MEDICAL LICENSE NO **01018611** DATE SIGNED (Month, Day, Year) **3-4-91**

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Dr. Adolphus Anekwe, 3195 Broadway, Gary, Indiana 46409**

HEALTH OFFICER'S SIGNATURE **[Signature]** DATE FILED (Month, Day, Year) **MAR. 05 1991**

MANNER OF DEATH  Natural  Pending Investigation  Accident  Suicide  Could not be Determined  Homicide

DATE OF INJURY (Month, Day, Year) **FILED** TIME OF INJURY **FILED** INJURY AT WORK? (Yes or no) **FILED** DESCRIBE HOW INJURY OCCURRED **FILED**

PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) **FILED** LOCATION (Street and Number or Rural Route Number, City or Town, State) **FILED**

DATE PRONOUNCED DEAD (Month, Day, Year) **FILED** MOTOR VEHICLE ACCIDENT? (Yes or no) **FILED** (driver, passenger, pedestrian, etc.) **FILED**

DATE PRONOUNCED DEAD (Month, Day, Year) **FILED** MOTOR VEHICLE ACCIDENT? (Yes or no) **FILED** (driver, passenger, pedestrian, etc.) **FILED**

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



Recipient: *Arrelen Carr, 2572 Washington St.*  
 Parents: *Arrelen Carr, 2572 Washington St.*  
 Informant: *Arrelen Carr, 2572 Washington St.*  
 Disposition: *Arrelen Carr, 2572 Washington St.*  
 Cause of Death: *Arrelen Carr, 2572 Washington St.*  
 Certifier: *Arrelen Carr, 2572 Washington St.*  
 Health Officer: *Arrelen Carr, 2572 Washington St.*  
 Coroner Use Only: *Arrelen Carr, 2572 Washington St.*

FILED

AUG 28 1991

*Arrelen Carr*  
 Auditor Lake County

01683

600



CERTIFIED BY

*David E. Johnson*

HEALTH COMMISSIONER  
CITY OF CARY, IND.

DATE MAR 10 5 1991