

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

Below for State Office Use

- A _____
- B _____
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- D _____
- E **FEB 25**
- F _____
- G **Case 2**
- H **AUDITOR LAKE COUNTY**
- I _____
- J _____
- K _____
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*Winters James Add
all ht 5' 5" wt 140
#47-466-5*

EMBALMER'S NAME *John R. Williams*
FUNERAL DIRECTOR'S SIGNATURE *John R. Williams*

FUNERAL HOME No. *752*
LICENSED DIRECTOR'S LICENSE No. *178*

92011516 Local No. **80-1016**

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No. _____
Date of Death **12-28-1980**

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK		DECEASED - NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (MONTH DAY YEAR)	
		1 <i>Melvin B. Kee</i>					<i>Male</i>	<i>12-28-1980</i>	
		RACE - (1) White (2) Black (3) American Indian (4) Other		AGE - (Last birthday)	LENGTH YEAR		LENGTH DAY	DATE OF BIRTH (Mo Day Yr)	COUNTY OF DEATH
		<i>Black</i>		<i>29</i>				<i>5-5-1951</i>	<i>Lake</i>
		CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION - (Name if not on other page street and number)				IF HOSP OR INST Institution DOA OR (Local, State, Federal or Other)	
		<i>Gary</i>		<i>Methodist Hospital</i>				<i>Inpatient</i>	
DECEASED:		STATE OF BIRTH (or not in U.S.A.)	CITIZEN OF WHAT COUNTRY		MARRIED NEVER MARRIED WIDOWED, DIVORCED (State of)		SURVIVING SPOUSE (if name give maiden name)		WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
		<i>Ind.</i>	<i>U.S.A.</i>		<i>Never Married</i>				<i>No</i>
		SOCIAL SECURITY NUMBER		USUAL OCCUPATION (Give kind of work done during most of working life even if retired)				KIND OF BUSINESS OR INDUSTRY	
		<i>304-58-9367</i>		<i>Unemployed</i>					
		RESIDENCE - STATE	COUNTY	CITY, TOWN OR LOCATION					
		<i>Ind.</i>	<i>Lake</i>	<i>Gary</i>					
		STREET AND NUMBER		IS RESIDENCE ON A FARM?				INSIDE CITY LIMITS (Specify Yes or No)	
		<i>1542 Noble St.</i>		18a YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				18b Yes	
		IS DECEASED OF SPANISH OR PORTUGUESE ORIGIN? (Specify Yes or No)							
		18c YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
PARENTS		FATHER - NAME			MOTHER - MAIDEN NAME				
		<i>Wiley Kee</i>			<i>Bernice Morris</i>				
		INFORMANT - NAME (If type or print)		RELATIONSHIP	MAILING ADDRESS		CITY OR TOWN STATE ZIP		
		<i>Wiley Kee</i>		<i>Father</i>	<i>1542 Noble St. Gary, Ind.</i>				
DISPOSITION		BURIAL, CREMATION, REMOVAL, OTHER (Specify)			CEMETERY OR CREMATORY - FUNERAL HOME		LOCATION CITY OR TOWN STATE		
		<i>Burial</i>			<i>Evergreen Memorial Park</i>		<i>Hobart, Ind.</i>		
		DATE (MONTH DAY YEAR)		FUNERAL HOME - NAME AND ADDRESS		(STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP)			
		<i>1-2-1981</i>		<i>Hinton-Williams</i>		<i>4859 Alexander Ave. East Chicago, Ind. 463</i>			
		To the best of my knowledge death occurred at the place indicated and the date is the actual date		DATE SIGNED (Mo. Day Yr.)		ROBERT JOSEPH RECORDED		STATE OF INDIANA S.S. LAKE COUNTY FILED FOR RECORD	
		21a (Signature) <i>Bernardo Saavedra MD</i>		<i>12-29-80</i>		<i>3 26 19</i>		<i>1:AM</i>	
M.D. OR D.O.		NAME OF ATTENDING PHYSICIAN (Type or Print)			MAILING ADDRESS - PHYSICIAN				
		<i>Bernardo Saavedra, M.D.</i>			<i>5490 Broadway Plaza, Merrillville, IN 46410</i>				
		HEALTH OFFICER - SIGNATURE			DATE RECEIVED BY LOCAL HEALTH OFFICER				
		<i>E. H. Caldwell, M.D.</i>			<i>DEC 30 1980</i>				
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST		PART I		PART II					
		(a) <i>Severe Subarachnoid Hemorrhage</i>		OTHER SIGNIFICANT CONDITIONS - (Conditions contributing to death but not related to cause given in PART I)					
		DUE TO OR AS A CONSEQUENCE OF							
		(b)							
		DUE TO OR AS A CONSEQUENCE OF							
		(c)							
CAUSE		PART II							



SBH 06-003 State Form 3543u
REV. 10/77
*R. Williams Allen
1820 E 142nd St
E. Chicago 46312*

*01078 to CC
GMP*

1078

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STOP



CERTIFIED BY:

William E. Foster, M.D.

HEALTH COMMISSIONER
CITY OF GARY, IND.

OCT 24 1991

DATE _____