

INDIANA STATE BOARD OF HEALTH

Continuation #2 of SD 10-12-82  
Rev. 11-3-2005, 3, 011-1-25

Local No. ... 91-0324 ..... 92013421

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle Last) <b>Laverne Dorsey Williams</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>5:20 P.M.</b>	3b DATE OF DEATH (Month Day Yr) <b>April 19, 1991</b>	
4 SOCIAL SECURITY NUMBER <b>252-40-5162A</b>	5a AGE—Last Birthday (Years) <b>66</b>	5b UNDER 1 YEAR Months Days Hours Minutes	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>March 28, 1925</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Philadelphia, MS</b>	8a WAS DECEDENT A US VETERAN? <b>No</b>	8b YEAR LAST SERVED IN US ARMED FORCES? <b>N/A</b>	9 PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence <input checked="" type="checkbox"/>		
10 FACILITY NAME (If not institution, give street and number) <b>2535 W. 19th Ave.</b>		11 CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>		12 COUNTY OF DEATH <b>Lake</b>	
13 MARITAL STATUS (Specify) <b>Married</b>	14 SURVIVING SPOUSE (If wife, give maiden name) <b>Nathaniel Williams</b>	15 DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). <b>Housewife</b>		16 KIND OF BUSINESS/INDUSTRY <b>Residence</b>	
17a RESIDENCE—STATE <b>Indiana</b>	17b COUNTY <b>Lake</b>	17c CITY, TOWN OR LOCATION <b>Gary</b>		17d STREET AND NUMBER <b>2535 W. 19th Ave.</b>	
18a ZIP CODE <b>46404</b>	18b INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	18c CITIZEN OF WHAT COUNTRY? <b>USA</b>	18d WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	18e RACE—American Indian, Black, White, etc. (Specify) <b>Black</b>	
18f DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <input type="checkbox"/> College (11-4 or 5+) <b>unknown</b>		19 FATHER'S NAME (First Middle Last) <b>Wiley Clemons</b>			
19b MOTHER'S NAME (First Middle Last) <b>Ruth Greenlee</b>			20a INFORMANT'S NAME (Type/Print) <b>Nathaniel Williams</b>		
20b ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2535 W. 19th Ave. Gary, In. 46404</b>			20c Relationship <b>Husband</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>April 26, 1991 Evergreen Cemetery</b>		21c LOCATION—City or Town, State <b>Hobart, Indiana</b>	
22a EMBALMER'S NAME <b>Roosevelt Allen Sr.</b>		22b EMBALMER'S LICENSE NO. <b>01051696</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Rosey L. Allen</i>		24b LICENSE NUMBER <b>#01045736</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Guy &amp; Allen Funeral Dir, INC 83007704 2959 W. 11th Ave. Gary, IN. 46404</b>	
26 PART I IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Cardiac arrest</b>		27 DATE FILED (Month Day, Year) <b>APR 24 1991</b>			
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>Hypertension, Angina</b>		28a CERTIFIER (Check only one) <input checked="" type="checkbox"/> IDENTIFYING 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.			
28b SIGNATURE AND TITLE OF CERTIFIER <i>Paul L. Steele</i>		28c MEDICAL LICENSE NO. <b>29392</b>		28d DATE SIGNED (Month Day, Year) <b>4/23/91</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>HARSH DALAL 3229 BROADWAY, GARY 46409</b>					
31 HEALTH OFFICER'S SIGNATURE <i>John E. Jones</i>			32 DATE FILED (Month Day, Year) <b>APR 24 1991</b>		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidents <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
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) <b>1118 W. 19th</b>			
34g DATE PRONOUNCED DEAD (Month Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) <b>No</b>			

DECEDENT

PARENTS

INFORMANT

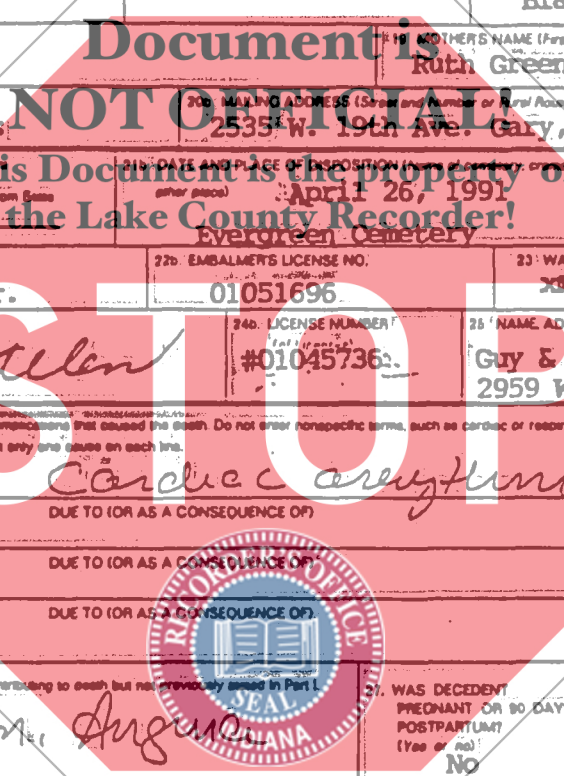
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



2 53 PM '92  
RECORDED  
INDEXED  
APR 23 1991

SBH06-004 State Form 10110 (R2/3-89) DEACERT/011  
*Gary Real Estate 105 E 61st Ave. Merrill 46410* **00220**  
**AUDITOR LAKE COUNTY**



CERTIFIED BY

*Theresa E. [unclear]*

HEALTH COMMUNITY CENTER  
CITY OF CHICAGO, ILL.

DATE MAR. 4 1992