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92035298

INDIANA STATE BOARD OF HEALTH

Local No. 92-0077

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Willie Kidd Jr.
2. SEX: Male
3a. TIME OF DEATH: 6:40 a.m.
3b. DATE OF DEATH (Mo. Day, Yr.): January 30, 1992
4. SOCIAL SECURITY NUMBER: 313-34-3845
5a. AGE—Last Birthday (Years): 55
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): May 31, 1936
7. BIRTHPLACE (City and State or Foreign Country): Mississippi
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 559 Mount Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Dorothy L. Smith
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright
12b. KIND OF BUSINESS/INDUSTRY: USX
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 559 Mount Street
13e. ZIP CODE: 46406
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Willie Kidd Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Short

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Dorothy L. Kidd
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 559 Mount Street Gary, IN. 46406
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): February 5, 1992 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO.: 01051701
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Roosevelt Allen
24b. LICENSE NUMBER (of Licensee): 01051701
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 8300770 Guy & Allen Funeral Directors, In 2959 W.11th Ave. Gary, IN. 46404

CAUSE OF DEATH

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. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: years

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 mentioned 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): ——

CERTIFIER

29a. 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

29b. SIGNATURE AND TITLE OF CERTIFIER: John Kolettis
29c. MEDICAL LICENSE NO: 017087
29d. DATE SIGNED (Month, Day, Year): Feb. 4, 1992

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. JOHN KOLETTIS 6111 HARRISON STREET MERRILLVILLE, INDIANA 46403
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): FEB. 7 1992

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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 Ooccurred:
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): JUN 2 1992
34h. MOTOR VEHICLE ACCIDENT? (Yes or no):
AUDITOR LAKE COUNTY
00182

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

HEALTH COMMISSIONER
CITY OF GARY, IND.
FEB. 7 19