

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 92-0184..... 92050963

State No. 7 *Mattie Harrison*  
4233 West 27th Ave.  
Gary, Ind 46404

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (Print Name Last, First Middle Initial) <b>George James</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>7:48 AM</b>	3b DATE OF DEATH (Month, Day, Year) <b>March 10, 1992</b>	
4 SOCIAL SECURITY NUMBER <b>244-09-3500</b>	5a AGE—Last Birthday (Years) <b>74</b>	5b UNDER 1 YEAR Months Days <b>7 14</b>	5c UNDER 1 DAY Hours Minutes <b>7 48</b>	6 DATE OF BIRTH (Month, Day, Year) <b>November 1, 1917</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Greer, North Carolina</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	8c PLACE OF DEATH (Check only one box) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> D.O.A. OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9a FACILITY NAME (If not institution, give street and number) <b>4233 West 27th Avenue</b>		9b CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>	9c COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Mattie Harrison</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Carpenter</b>		12b KIND OF BUSINESS/INDUSTRY <b>Local #105</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Gary</b>	13d STREET AND NUMBER <b>4233 West 27th Avenue</b>		
14a ZIP CODE <b>46404</b>	14b INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14c CITIZENSHIP OF WHAT COUNTRY <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>Black</b>	
17 DECEDENT'S EDUCATION (Specify any highest grade completed) Elementary/Secondary (9-12) <b>8th</b>		18 COLLEGE (1-4 or 5+)			
19 FATHER'S NAME (Print Name Last) <b>George James</b>		20 MOTHER'S NAME (Print Name Last) <b>Grace Foster</b>			
21 INFORMANT'S NAME (Type Print) <b>Nathaniel James</b>		22 MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>432 Calhoun Street, Gary, Indiana 46404</b>	23 Relationship <b>Son</b>		
24 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)		25 DATE OF BURIAL <b>March 14, 1992</b>		26 LOCATION—City or Town, State <b>Evergreen Cemetery, Hobart, Indiana</b>	
27a EMBALMER'S NAME <b>Roosevelt Allen Jr.</b>		27b EMBALMER'S LICENSE NO. <b>#01051701</b>	28 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
29 SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		30 LICENSE NUMBER (of License) <b>08700646</b>	31 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Guy &amp; Allen Funeral Directors, Inc. 83007704 2959 W. 11th Avenue Gary, Indiana 46404</b>		
32 PART I Enter the disease, injury, or condition that caused the death. Do not enter etiologic terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiovascular arrest</b>					
33 IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Cardiovascular arrest</b>					
34 CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last <b>Cardiovascular arrest</b>					
35 PART II Other significant conditions - Conditions contributing to death but not proximately related <b>None</b>					
36 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 checked="" 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 I appear so stated.		37 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		38 WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	
39 SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		39a MEDICAL LICENSE NO. <b>0038025</b>	39b DATE SIGNED (Month, Day, Year) <b>4/14/92</b>		
40 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type Print) <b>Dr. Yanis 5490 Broadway Merrillville, Indiana 46410</b>					
41 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				42 DATE FILED (Month, Day, Year) <b>APR 23 1992</b>	
43 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		44a DATE OF INJURY (Month, Day, Year)	44b TIME OF INJURY	44c INJURY AT WORK? (Yes or no)	44d DESCRIBE HOW INJURY OCCURRED
45 PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		46 LOCATION (Street and Number or Rural Route Number, City or Town, State)			
47 DATE PRONOUNCED DEAD (Month, Day, Year)		48 MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>02096</b>			

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49-403-21, 22, 30, 31  
#3  
Prop. Lt. 21, 22, 30, 31

PARENTS  
INFORMANT  
DISPOSITION  
CAUSE OF DEATH  
CERTIFIER  
HEALTH OFFICER  
CORONER USE ONLY



CERTIFIED BY:

*Heather E. Johnson*

HEALTH COMMISSIONER  
CITY OF GARY, IND.

DATE: JUL 28 1992