3954 Jackson St.
Gary IN 46408

92-0576

INDIANA STATE BOARD OF HEALTH

Local No. 92070812

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Meala Adams Stovall
2 SEX: Female
3a TIME OF DEATH: 3:25pm
3c DATE OF DEATH (Month Day Year): August 17, 1992
4 SOCIAL SECURITY NUMBER: 352-16-9384
5a AGE—Last Birthday (Years): 84
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): June 12, 1908
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? None
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL XX Inpatient; ER/Outpatient; DOA; OTHER Nursing Home; Other (Specify); Residence
9b FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
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): Arthur Stovall Sr.
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Housekeeper
12b KIND OF BUSINESS/INDUSTRY: Hospital Industry
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2047 East 20th Ave
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS: No XX Yes
13g ON A FARM? XX No Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 8; College (1-4 or 5+): 5

PARENTS

18 FATHER'S NAME (First Middle Last): Will Whiteside
19 MOTHER'S NAME (First Middle Maiden Surname): Lizzie Stone

INFORMANT

20a INFORMANT'S NAME (Type/Print): Arthur Stovall Sr.
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2047 East 20th Ave Gary IN 46407
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: XX Burial; Cremation; Entombment; Removal from State; Donation; Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): August 21, 1992 Oak Hill Cemetery
21c LOCATION—City or Town State: Gary Indiana
22a EMBALMER'S NAME: Patrician Owens
22b EMBALMER'S LICENSE NO: 08700298
23 WAS DEATH REPORTED TO CORONER? XX No Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Valerie L Broadus
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors, Inc 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

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a ACUTE RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF)
b
DUE TO (OR AS A CONSEQUENCE OF)
c
DUE TO (OR AS A CONSEQUENCE OF)
d

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 stated 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):
XX 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: Patricia Myers MD
29c MEDICAL LICENSE NO: 01032692
29d DATE SIGNED (Month Day Year): 9/3/92

Cook Plat of Marshalltown Lot 3 Block 8

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR D Vyas 3229 Broadway Gary, IN 46408
31 HEALTH OFFICER'S SIGNATURE: Rebecca E Foston MD MPH
32 DATE FILED (Month Day Year): SEP. 3 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 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)
34g DATE PRONOUNCED DEAD (Month Day Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian

FILED
NOV 9 1992
AUDITOR LAKE COUNTY
00425

SBH06 004 State Form 10110 (R2/3-89) DEA CERTIFIED

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