Key # 47-389-5
Young's Highlands
L.5 + S. 5 Ft of L.4 Bl.8

92 0921 INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 93013247 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Harold Wayne Hannah Sr.
2. SEX: Male
3a. TIME OF DEATH: 2:30 a.m.
3c. DATE OF DEATH (Month Day Yr): December 23, 1992
4. SOCIAL SECURITY NUMBER: 490-48-0708
5a. AGE—Last Birthday (Years): 47
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): Mar. 22, 1945
7. BIRTHPLACE (City and State or Foreign Country): Moberly, Missouri
8a. WAS DECEDENT A US VETERAN?: No
8b. YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake Campus
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): Suzette Sconiers
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steelworker
12b. KIND OF BUSINESS/INDUSTRY: Bethelhem Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 1045 N. Tippecanoe Street
13e. ZIP CODE: 46403
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Afro Amer
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Harold Walter Hannah Sr.
19. MOTHER'S NAME (First Middle Maiden Surname): Betty Erickson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Suzette Hannah
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1045 N. Tippecanoe St., Gary, IN 46403
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): December 28, 1992 Oakhill Crematory
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FDO 1016254
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Paula L. Warner
24b. LICENSE NUMBER (of Licensee): FD09100591
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell Warner & Son, 4209 Grant St., Gary, IN 46408 FH89900011

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. Metastatic Cancer of Stomach — Approximate Interval Between Onset and Death: 20 Months
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: Kidney Failure
27. WAS DECEDENT PREGNANT IN 90 DAYS OF DEATH?: No
28a. WAS AN AUTOPSY PERFORMED?: No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): 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: Barbara L. Fuller, M.D.
29c. MEDICAL LICENSE NO.: 01034701
29d. DATE SIGNED (Month Day Year): 12/23/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Barbara L. Fuller, M.D. 3229 Broadway Gary, Indiana 46408

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month Day Year): DEC 30 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, etc.

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SDH06-004 State Form 10110 (R/1-92) DEATHCERPD

FILED MAR 1 1993
Anna M. Antone
RECORDER LAKE COUNTY

STATE OF INDIANA / LAKE COUNTY / FILED FOR RECORD
93 MAR 9 ... HERBERT ... RECORDER

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE JAN 5 1998