

John Henry Hatt
1937
Madison
Gary 463

Re-sub Gary Land Co's 3rd Sub
Lot 11 & N 10 ft lot 12, Block 12
Key #44-145-9

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 49 Unit # 25
93015200

CERTIFICATE OF DEATH

State No. 7

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

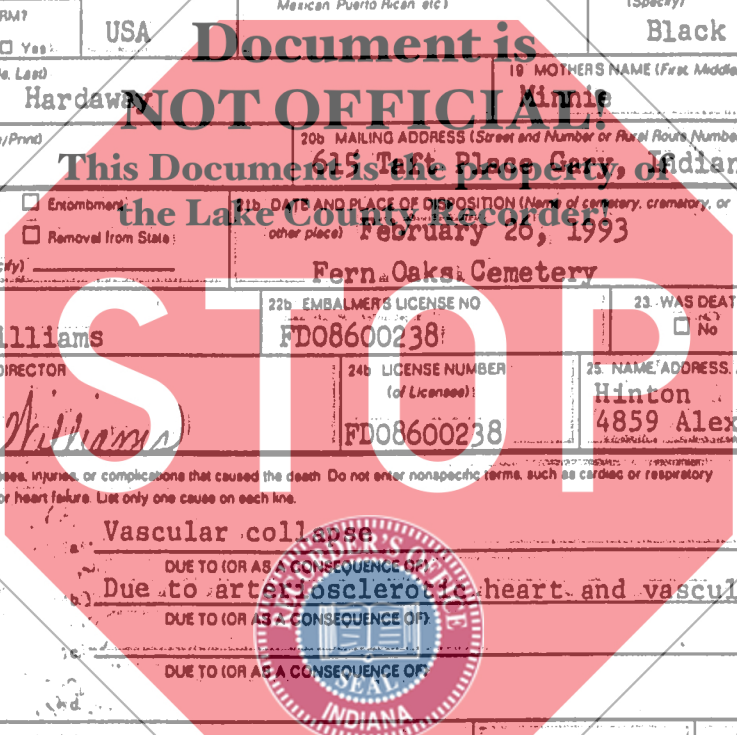
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) William Dan Hardaway		2 SEX Male	3a TIME OF DEATH 1:27 P M	3b DATE OF DEATH (Month Day Year) February 22, 1993
4 SOCIAL SECURITY NUMBER 306-24-9110	5a AGE—Last Birthday (Years) 65	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) June 2, 1927
7 BIRTHPLACE (City and State or Foreign Country) Eufaula, Alabama	8a WAS DECEDENT A US VETERAN? No		8b YEAR LAST SERVED IN US ARMED FORCES? -----	
9a PLACE OF DEATH (Check only one See instructions)				
9b FACILITY NAME (If not institution give street and number) St. Catherine Hospital		9c CITY, TOWN OR LOCATION OF DEATH East Chicago		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Widower	11 SURVIVING SPOUSE (If wife give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Craneman (Retired)		12b KIND OF BUSINESS/INDUSTRY LTV Steel
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary		13d STREET AND NUMBER 522 Buchanan
13e ZIP CODE 46402	13f INSIDE CITY LIMITS? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) Black
16 FATHER'S NAME (First Middle Last) Sanford Hardaway		17 MOTHER'S NAME (First Middle Maiden Surname) Minnie Pugh		
20a INFORMANT'S NAME (Type/Print) Regina Parks		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 East Place Gary, Indiana 46404		20c Relationship Daughter
21a 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)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) February 26, 1993 Fern Oaks Cemetery		21c LOCATION—City or Town, State Griffith, Indiana
22a EMBALMER'S NAME Tracy Cheri Williams		22b EMBALMER'S LICENSE NO. FD08600238		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b LICENSE NUMBER (of Licensee) FD08600238		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Hinton Williams Funeral Home 4859 Alexander, East Chicago, IN4631
26. PART I Enter the disease, 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) Vascular collapse Due to (OR AS A CONSEQUENCE OF) Due to arteriosclerotic heart and vascular disease				
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
27 WAS DECEDENT PREPREGNANT 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)
29a CERTIFIER (Check only one): <input 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 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 checked="" 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.				
29b SIGNATURE AND TITLE OF CERTIFIER <i>Daniel D. Thomas</i>		29c MEDICAL LICENSE NO. 16120		29d DATE SIGNED (Month Day, Year) February 23, 1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307				
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Lonkovich</i>				32 DATE FILED (Month Day, Year) 2-25-93
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no) FILED
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) MAR 9 1993		
34g DATE PRONOUNCED DEAD (Month Day, Year) February 22, 1993		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian. <i>Clare N. Anton</i> AUDITOR LAKE COUNTY		



STATE OF INDIANA
FILED
REC'D
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1993