Robert L. Lewis
3128 W. 11th ave
Gary 46404

93015306

5cc
92-0041

Local No. ....

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): William P. Terry, Jr.
2 SEX: Male
3a TIME OF DEATH: 2:45a M
3b DATE OF DEATH (Month Day Yr): Jan. 10th, 1992
4 SOCIAL SECURITY NUMBER: 417-26-1563
5a AGE—Last Birthday (Years): 67
5b UNDER 1 YEAR (Months, Days)
5c UNDER 1 DAY (Hours, Minutes)
6 DATE OF BIRTH (Mo Day Yr): Feb. 16th, 1924
7 BIRTHPLACE (City and State or Foreign Country): Mobile, AL.
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 ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Mary's Medical Center
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): Annie L. Wright
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer
12b KIND OF BUSINESS/INDUSTRY: Steel Mill
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 971 Hanley St
13e ZIP CODE: 46404
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First Middle Last): William P. Terry, Sr.
19 MOTHER'S NAME (First Middle Maiden Surname): Arcory Gates

INFORMANT

20a INFORMANT'S NAME (Type/Print): Annie L. Terry
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 971 Hanley St Gary IN 46404
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Fri. Jan 17th, 1992 Fern Oaks Cemetery
21c LOCATION—City or Town, State: Griffith, In.
22a EMBALMER'S NAME: Celeste P. Kaufman
22b EMBALMER'S LICENSE NO: Fde; 1033626
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Celeste P. Kaufman
24b LICENSE NUMBER (of Licensee): FDH; 3002411
25 NAME AND ADDRESS OF FUNERAL HOME: KAUFMAN FUNERAL HOME INC. 421 WEST 5TH AVE. GARY, INDIANA 46402 FDH: 3002411

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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): CVA
DUE TO (OR AS A CONSEQUENCE OF): Dysphagia, quadriplegia, global aphasia
DUE TO (OR AS A CONSEQUENCE OF): ASHD
DUE TO (OR AS A CONSEQUENCE OF): Status - gastric tube feeding

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Approximate Interval Between Onset and Death

PART II. Other significant conditions—Conditions contributing to death but not resulting in the underlying cause: Seizure disorder
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): 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.

FILED

29b SIGNATURE AND TITLE OF CERTIFIER: Fred S Cho M.D
MAR 05 1993
29c MEDICAL LICENSE NO: 26003
29d DATE SIGNED (Month Day Year): Jan 13-92

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Fred S. Cho, M.D., 9129 Soutwood Dr., Munster, Ind 46321 (219)972-0012

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD
[signature] AUDITOR LAKE COUNTY
32 DATE FILED (Month Day Year): JAN 21 1992

CORONER USE ONLY

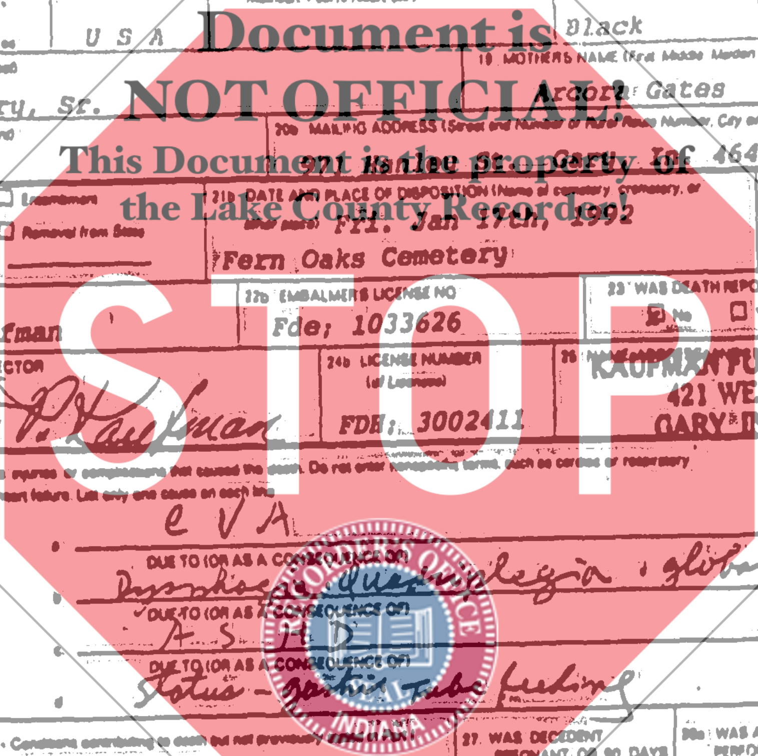
33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office building, 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.

00176

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

45-340-23 A.R. Tuttis 1st Addl. Lot 24 Blk 1 ... 3/5/93

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD ... MAR 8 ... ALL '93 ... RECORDER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