93015990 INDIANA STATE BOARD OF HEALTH

Local No. 92-0637

CERTIFICATE OF DEATH

State No.

Terry C. Gray 7240 N. 11th

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Warree Mills
2 SEX: Female
3a TIME OF DEATH: 10:05a.m.
3b DATE OF DEATH (Month Day Yr): September 11,1992
4 SOCIAL SECURITY NUMBER: 317-20-6192
5a AGE—Last Birthday (Years): 74
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo, Day, Yr): October 9,1917
7 BIRTHPLACE (City and State or Foreign Country): Little Rock,AR
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 ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 1632 Virginia Street
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): James Mills
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b KIND OF BUSINESS/INDUSTRY: Residence
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1632 Virginia St
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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) College (1-4 or 5+)

PARENTS

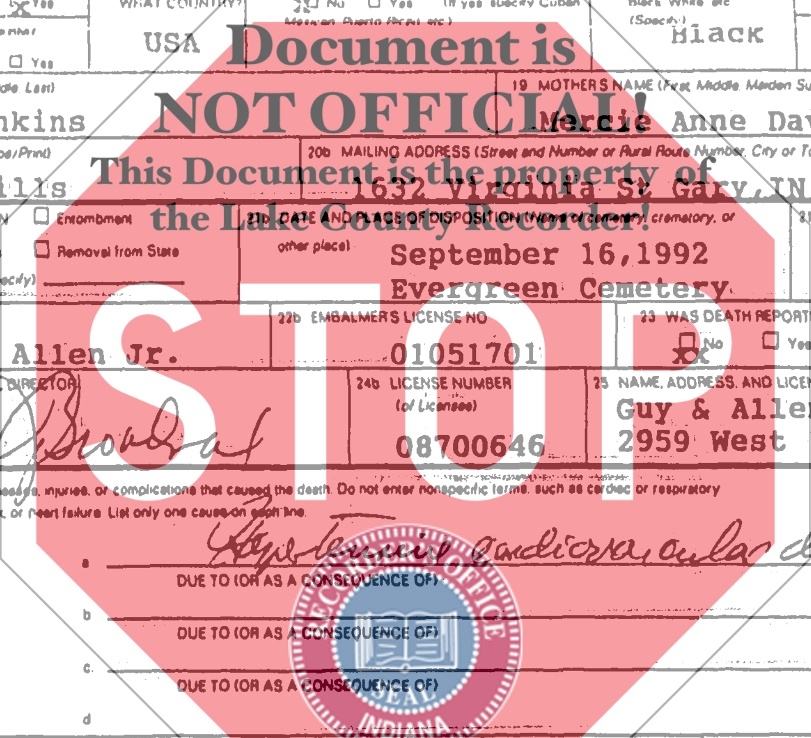
18 FATHER'S NAME (First Middle Last): Lonnie Jenkins
19 MOTHER'S NAME (First Middle Maiden Surname): Mercie Anne Davis

INFORMANT

20a INFORMANT'S NAME (Type/Print): James A Mills
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1632 Virginia St Gary,IN 46407
20c Relationship: Husband

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): September 16,1992 Evergreen Cemetery
21c LOCATION—City or Town, State: Hobart,Indiana
22a EMBALMER'S NAME: Roosevelt Allen Jr.
22b EMBALMER'S LICENSE NO: 01051701
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Director,In 2959 West 11th Ave. Gary,IN 4640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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. Hypertensive cardiovascular disease
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: Diverticulosis

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): —

MAR 12 8 45 AM '93 SAINT ELLIOTT RECORDER
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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: [signature] MD
29c MEDICAL LICENSE NO: 01016449
29d DATE SIGNED (Month, Day, Year): 9/17/92

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR BORNSTEIN 3290 GRANT STREET GARY,INDIANA 46408

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD MPH
32 DATE FILED (Month, Day, Year): SEP. 18 1992

FILED

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? If yes, specify driver, passenger, pedestrian, etc.

MAR 11 1993

[signature] AUDITOR LAKE COUNTY

00505

SBH00-004 State Form 10110 (R2/3-89)