

93016963

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 88-6596

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME FIRST MIDDLE LAST WILLIAM BRICE SIMS				2 SEX MALE	3 DATE OF DEATH (Month Day Year) AUGUST 29, 1988
4 SOCIAL SECURITY NUMBER 235-07-1879	5a AGE—Last Birthday (Year) 72	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) 5/30/1916	7 BIRTHPLACE (City and State or Foreign Country) TUSKEEGEE, ALABAMA

DECEDENT

8 YEAR LAST SERVED IN U.S. ARMED FORCES? NO		9a PLACE OF DEATH (Check any and See instructions) HOSPITAL <input checked="" type="checkbox"/> Institution <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not registered, give street and number) METHODIST HOSPITAL NORTHLAKE			9c CITY TOWN OR LOCATION OF DEATH GARY		9d COUNTY OF DEATH LAKE

10 MARITAL STATUS—Married Never Married Widowed MARRIED	11 SURVIVING SPOUSE (If wife give maiden name) ESSIE LEWIS	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life) STEELWORKER	12b KIND OF BUSINESS/INDUSTRY GARY SHEET & TIN
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13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION GARY	13d STREET AND NUMBER 2701 HARRISON ST.
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13e INSIDE CITY LIMITS? (Yes or no) YES	13f FARM NO	13g ZIP CODE 46407	14 WAS DECEASED OF HISPANIC ORIGIN? (Specify No or Yes. If yes specify Cuban Mexican Puerto Rican etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes BLACK	15 RACE—American Indian Black White etc. BLACK	16 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) College (1-6 or 8+)
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PARENTS

17 FATHER'S NAME (Type or Print) BRICE CURTIS SIMS	18 MOTHER'S NAME (Type or Print) JANIE SHELTON
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INFORMANT

19a INFORMANT'S NAME (Type or Print) ESSIE SIMS	19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 2701 HARRISON ST. GARY, IN 46407	19c Relationship WIFE
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DISPOSITION

20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) SEPTEMBER 11, 1988 GARY, INDIANA	20c LOCATION—City or Town State GARY, INDIANA
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PRONOUNCING PHYSICIAN ONLY

21a SIGNATURE OF FUNERAL DIRECTOR <i>Patricia Jones</i>	21b LICENSE NUMBER (of Licensee) 8700298	21c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME GUY & ALLEN FUNERAL DIRECTORS INC. 2959 W. 11th Ave. #3007704
22a To the best of my knowledge death occurred at the time date and place stated Signature and Title < <i>Patricia Jones</i>		22b LICENSE NUMBER
23a To the best of my knowledge death occurred at the time date and place stated		23c DATE SIGNED (Month Day Year) SEP 1 1988

SEE INSTRUCTIONS

24 TIME OF DEATH 6:00 a.m.	25 DATE PRONOUNCED DEAD (Month Day Year) August 29, 1988	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) Yes
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CAUSE OF DEATH

27 PART I Enter the disease, 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. Cardio-respiratory Arrest Chronic Kidney Disease	28a WAS AN AUTOPSY PERFORMED? (Yes or no) Yes	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes
27 PART II: Other significant conditions contributing to death but not resulting in the underlying cause stated in Part I		

SEE INSTRUCTIONS

29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed form in this county. To the best of my knowledge death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death. To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.	29b LICENSE NUMBER 0032156	29c DATE SIGNED (Month Day Year) 8/31/88
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HEALTH OFFICER

30 SIGNATURE AND TITLE OF CERTIFIER <i>Donald Young Tucker</i>	31 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type or Print) Donald Young Tucker 1619 W. Hawthorne GARY, IN 46404
31 HEALTH OFFICER'S SIGNATURE <i>James T. Holladay</i>	32 DATE FILED (Month Day Year) SEP 1 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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)	

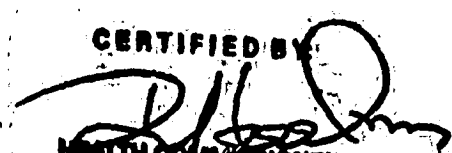


RECORDED 10 06 AM '88

FILED

Vertical text on the left margin: 'StoA v B...', '# 46-225-23', '2nd Oak Rk.', 'CORONER OR MEDICAL EXAMINER USE ONLY'.



CERTIFIED BY:

**HEALTH COMMISSIONER
CITY OF GARY, IND.**
DATE MAR 15 1988