Local No. 2403-90
93019680

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Key# 46-387-22
Pridmore, Orr & Ulrichs Sub. L23 BL4
State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Fannie Mable Pullen
2. SEX: Female
3a. TIME OF DEATH: 11:22 a.m.
3b. DATE OF DEATH (Month, Day, Yr): November 17, 1990
4. SOCIAL SECURITY NUMBER: 307-01-7252
5a. AGE—Last Birthday (Years): 89
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): February 5, 1901
7. BIRTHPLACE (City and State or Foreign Country): Roanoke, VA.
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c. CITY, TOWN OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Never Married
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Presser
12b. KIND OF BUSINESS/INDUSTRY: United Cleaners
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 4541 East 13th Place
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 10th; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Unknown
19. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Deatrice Woods
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4541 East 13th Place Gary, Indiana 46404
20c. Relationship: Niece

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Other (Specify) ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 24, 1990 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO.: #01051701
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): #08700646
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W. 11th Ave. Gary, In. 46404

THIS CERTIFIES ... COMPLETE ... DEATH ON ... HEALTH D...

83007704

JUL 08 1993

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Coronary artery disease	5 yrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Congestive heart failure	5 yrs
DUE TO (OR AS A CONSEQUENCE OF): c.	Urinary tract infection c Sepsis	10 days
DUE TO (OR AS A CONSEQUENCE OF): d.		

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

LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not resulting in the underlying cause given in Part I: Organic Brain Syndrome

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):

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.: 01033337
29d. DATE SIGNED (Month, Day, Year): 11.26.90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): F. Quwt 820A Co. Sq. Plaza Hebron IN 46341

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
FILED
32. DATE FILED (Month, Day, Year): November 30, 1990

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:

MAR 31 1993

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):

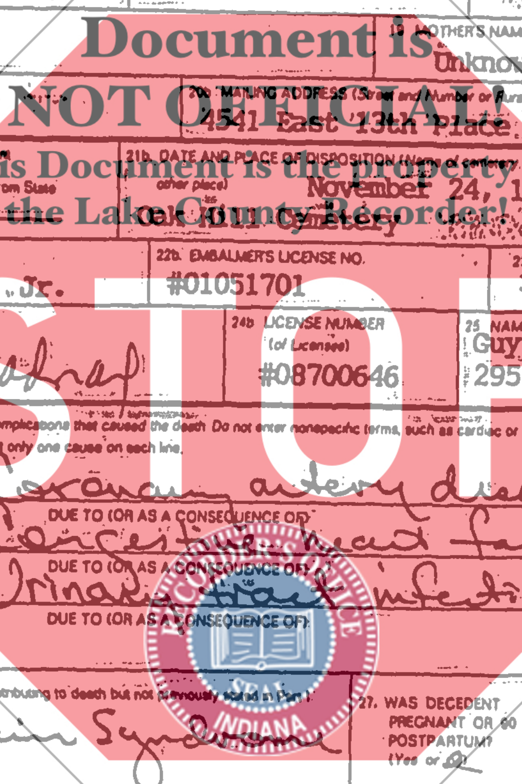
[signature] Anne N. Anton
AUDITOR LAKE COUNTY

34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

ST. John Spiritual Church
4017 Rhode Island Gary 46409

01622 600



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