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Wyatt, Janie  
1977 Penn St ←  
Gary, In

INDIANA STATE BOARD OF HEALTH

91-0417

CERTIFICATE OF DEATH

State No. ....

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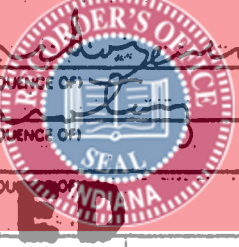
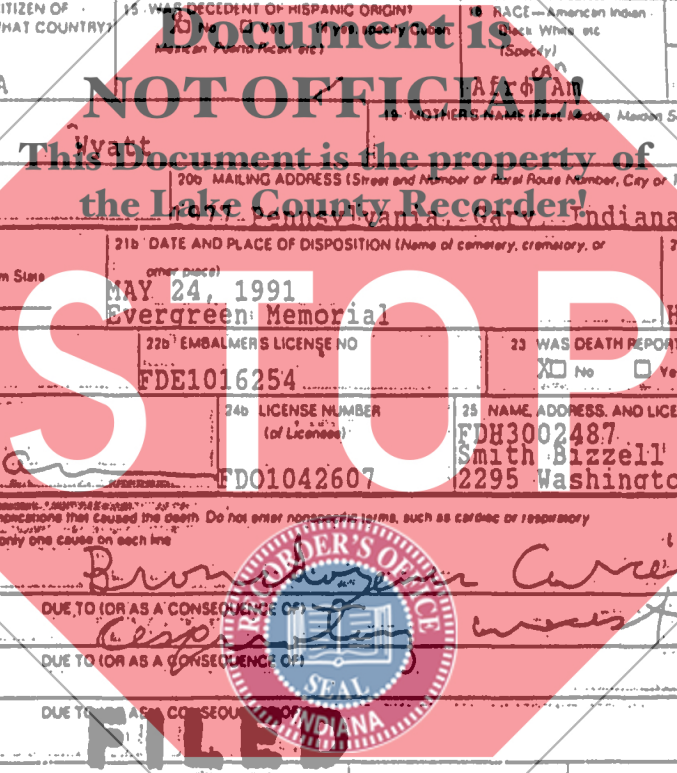
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1. DECEASED—NAME (First Middle Last) <b>Jefferson Wyatt Sr.</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>03:20P</b>	3b. DATE OF DEATH (Month Day, Yr) <b>May 20, 1991</b>
4. SOCIAL SECURITY NUMBER <b>307-01-59331</b>	5a. AGE—Last Birthday (Years) <b>75</b>	5b. UNDER 1 YEAR Meninge Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day, Yr) <b>FEB 14, 1916</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Canton, Mississippi</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	8c. PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary medical center</b>		9b. CITY, TOWN, OR LOCATION OF DEATH <b>Gary</b>	9c. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Janie Chandler</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Steelworker</b>	12b. KIND OF BUSINESS/INDUSTRY (Specify only hospital grade completed) <b>USX Big Mill</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Gary</b>	13d. STREET AND NUMBER <b>1977 Pennsylvania Street</b>	
13e. ZIP CODE <b>46407</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify) <b>ABYCAN</b>	16. RACE—American Indian (Specify White, etc) <b>W</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <input type="checkbox"/> College (11-6 or 9-9) <input type="checkbox"/> <b>10</b>		18. FATHER'S NAME (First Middle Last) <b>Elijah Wyatt</b>		
19. MOTHER'S NAME (First Middle Maiden Surname) <b>Mary</b>		20a. INFORMANT'S NAME (Type/Print) <b>Janie Wyatt</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1977 Pennsylvania, Gary, Indiana 46407</b>		20c. Relationship <b>Wife</b>		
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) <b>MAY 24, 1991 Evergreen Memorial</b>		21c. LOCATION—City or Town State <b>Hobart, Indiana</b>
22a. EMBALMER'S NAME <b>Sherman G. Banks</b>		22b. EMBALMER'S LICENSE NO. <b>FDE1016254</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Edgar Warner</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01042607</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Smith Bizzell &amp; Warner 2295 Washington St. Gary, In. 46407</b>
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. <b>Bronchopneumonia</b> <b>Aspiration pneumonia</b>				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death):				
a. DUE TO (OR AS A CONSEQUENCE OF) _____				
b. DUE TO (OR AS A CONSEQUENCE OF) _____				
c. DUE TO (OR AS A CONSEQUENCE OF) _____				
d. DUE TO (OR AS A CONSEQUENCE OF) _____				
PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I				
APR 5 1993		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Janie J. Warner</i> <b>AUDITOR LAKE COUNTY</b>		
29c. MEDICAL LICENSE NO. <b>50002601</b>		29d. DATE SIGNED (Month, Day, Year) <b>6-1-91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CRUISE OF DEATH (ITEM 26) (Type/Print) <b>Dr. W. E. Washington, 1400 Broadway, Gary, Indiana 46407</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Robert C. Kistner</i>				32. DATE FILED (Month, Day, Year) <b>6-1-91</b>
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. PLACE OF INJURY—At home, farm, street, factory, office, building, etc (Specify)		34e. DESCRIBE HOW INJURY OCCURRED		
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>00202</b>				
35a. DATE PRONOUNCED DEAD (Month, Day, Year)		35b. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc		

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