Wheeler & Pelly's Add
Lot 4, & E 15ft Lot 5 both Bl. 1

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

No. 91-0670 · 93024100

State No. Key #47-341-3, Unit #25

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
Major Davis			Male	12:45 p.m.	September 8, 1991
4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
317-09-4586	83			December 10, 1907	Seals, Alabama
8a. WAS DECEDENT EVER IN U.S. ARMED FORCES?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9. PLACE OF DEATH (Check only one. See instructions.)			
No	N/A	HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN, OR LOCATION OF DEATH	9c. COUNTY OF DEATH		
Methodist Hospital Northlake		Gary	Lake		
10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY		
Married	Fannie Pearl Pope	Line Operater	USX		
13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER		
Indiana	Lake	Gary	521 West 21st Ave.		
13e. ZIP CODE	13f. INSIDE CITY LIMITS ☐ No XX Yes	14. CITIZEN OF WHAT COUNTRY?	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)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)
46407	13g. ON A FARM? ☐ No ☐ Yes	USA		Black	Elementary/Secondary (0-12): 6th / College (1-4 or 5+):
18. FATHER'S NAME (First, Middle, Last)		19. MOTHER'S NAME (First, Middle, Maiden, Surname)			
Thomas Davis		Rhoda Nathan			
20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship			
Fannie P. Davis	521 West 21st Ave. Gary, In. 46407	Wife			
21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State	21b. DATE AND PLACE OF DISPOSITION (Cemetery, Crematory, Other Place)			21c. LOCATION—City or Town, State	
	September 14, 1991 Oak Hill Cemetery			Gary, IN.	
22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes			
Roosevelt Allen Jr.	01051701				
24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME			
[signature]	08700298	83007704 Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. Gary, In. 46404			

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.	SEPTICEMIA	10 Days
DUE TO (OR AS A CONSEQUENCE OF) b.	URINARY TRACT INFECTION	10 Days
DUE TO (OR AS A CONSEQUENCE OF) c.	PNEUMONIA	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

PART II: Other significant conditions: Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR IN 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	

29a. CERTIFIER (Check only one)
XX 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature] DR, Abramson	01017187	9-12-91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ALLAN L. ABRAMSON 3290 GRANT GARY IN 46408

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	SEP. 17 1991

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				
	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)	
			APR 16 1993	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

FILED
[signature]
LAKE COUNTY

609
00836

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

CERTIFIED BY
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE JAN. 1 1 1999