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93024188

Local No. 91-0747

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Lemar Johnson
2. SEX: Male
3a. TIME OF DEATH: 8:14 p.m.
3b. DATE OF DEATH (Month Day Yr): October 6,1991
4. SOCIAL SECURITY NUMBER: 312-05-5084
5a. AGE—Last Birthday (Years): 84
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): August 22,1907
7. BIRTHPLACE (City and State or Foreign Country): Amory,Mississippi
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 716 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): Bertha Davis
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 716 Virginia Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No X Yes
13g. ON A FARM? X No ☐ Yes
14. CITIZEN OF WHAT COUNTRY: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) X No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Not Available
19. MOTHER'S NAME (First, Middle, Maiden Surname): Not Available

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Bertha Johnson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 716 Virginia St. Gary, IN. 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: X Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 12,1991 Evergreen Cemetery
21c. LOCATION (City or Town, State): Hobart, IN.
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO: 01051701
23. WAS DEATH REPORTED TO CORONER? X 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... Funeral Directors, Inc. 2959 W... Gary, IN. 46404

FILED APR 16 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Acute cardio respiratory insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
b. Senility
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.

Approximate Interval Between Onset and Death:

PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I: — Prostatitis — Arthritis
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)

SAMUEL ... RECORDER
APR 16 4 ... '93
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] M.D.
29c. MEDICAL LICENSE NO.: 01026169
29d. DATE SIGNED (Month, Day, Year): 10/14/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26): MANUEL Z. ROSARIO, M.D. 504 BROADWAY GARY, IN 46402 TEL. #885-7756

HEALTH OFFICER

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

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:
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? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

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