INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 36 93027919 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED NAME (First Middle Last): BILLIE WANDA McBRAYER
2. SEX: FEMALE
3a. TIME OF DEATH: 12:01 AM
3b. DATE OF DEATH (Month Day Yr): JANUARY 31, 1991
4. SOCIAL SECURITY NUMBER: 309-30-8011
5a. AGE - Last Birthday (Years): 59
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): Dec. 13, 1931
7. BIRTHPLACE (City and State or Foreign Country): Deanfields, Kentucky
8a. WAS DECEDENT A U.S. VETERAN: no
8b. YEAR LAST SERVED IN US ARMED FORCES?: none
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): St. Catherine Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife give maiden name): Robert W. McBrayer
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 3137 Kenwood
13e. ZIP CODE: 46323
13f. INSIDE CITY LIMITS: ☐ No [X] Yes
13g. ON A FARM?: [X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc)
16. RACE—American Indian, Black, White, etc (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Ivo Williams
19. MOTHER'S NAME (First Middle Maiden Surname): Mabel Kirk

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mr. Robert W. McBrayer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3137 Kenwood Hammond, IN 46323
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): February 2, 1991 Elmwood Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: David McCoy
22b. EMBALMER'S LICENSE NO: FD08700581
23. WAS DEATH REPORTED TO CORONER?: [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01013507
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. Fh83002801 7042 Kennedy Ave. Hammond, IN 46323

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. Small Cell Carcinoma lung - Advanced stage
DUE TO (OR AS A CONSEQUENCE OF):
b.
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 related to cause given in Part I.

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)
[X] 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]
29c. MEDICAL LICENSE NO: 29782
29d. DATE SIGNED (Month Day Year): Jan. 31, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M.Y. ALI, M.D. 9116 COLUMBIA AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. [signature]
32. DATE FILED (Month Day Year): 2-1-91

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

00010 600

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

#35-398-8 Parkland Inn 2nd Rt 28

FILED FOR RECORD 22 APR '93 ... RECORDER