89 0152

INDIANA STATE BOARD OF HEALTH

Local No. 93028268

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First / Middle / Last)	2. SEX	3. DATE OF DEATH (Mo. Day Yr.)
EDDIE / DAVIS	M	3-8-89

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 (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
432-16-7055	78			10-31-1910	PINE BLUFF, ARK.

8. YEAR LAST SERVED IN U.S. ARMED FORCES?

9a. PLACE OF DEATH (Check only one) — HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing [redacted] ☐ Other (Specify)

9b. FACILITY NAME (If not institution give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. MARY MEDICAL CENTER	GARY [redacted]	LAKE

10. MARITAL STATUS—Married / Never Married / Widowed / Divorced (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	CELIA SEGREST	CONVALESCE[redacted]	LAKE COUNTY

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	GARY	3951 CONNECTICUT STREET 46404

13e. INSIDE CITY LIMITS? (Yes or no)	13f. FARM	13g. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE—American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)?	College (1-4 or 5+)
YES	NO	46404	☒ No ☐ Yes	BLACK	8TH	

Tx: Same

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROBERT DAVIS	INDIANA DAVIS

INFORMANT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c. Relationship
CELIA DAVIS	3951 CONNETICUT ST. GARY, IND 46404	WIFE

BL 13

DISPOSITION

20a. METHOD OF DISPOSITION	20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	OAKHILL CEMETERY-3-13-89	GARY, INDIANA

L17

PRONOUNCING PHYSICIAN ONLY

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (of Licensee)	22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[redacted]	01012356	ANDREW SMITH FUNERAL HOME 934 E. 21ST. AVE.-000120356

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge death occurred at the time, date, and place stated. Signature and Title	23b. LICENSE NUMBER	23c. DATE SIGNED (Month, Day, Year)

24. TIME OF DEATH	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
1 P M	3-8-89	NO

CAUSE OF DEATH

SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF)

b. Cardiac Dysrhythmia

DUE TO (OR AS A CONSEQUENCE OF)

c. Respiratory Failure

DUE TO (OR AS A CONSEQUENCE OF)

d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

3rd Hem Carb add

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. AUTOPSY PERFORMED? (Yes or no) No

28b. AUTOPSY FINDINGS CONSIDERED IN DETERMINATION OF CAUSE OF DEATH? (Yes or no)

FILED

MAY 4 1993

STATE OF INDIANA LAKE COUNTY CORONER'S OFFICE

10 28 AM '93

CERTIFIER

SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[redacted]	01033511	3/13/89

1-345-21

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)	
3535 Broadway Gary O. Nwabara, M.D.	

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[redacted]	MAR. 13 1989

CORONER OR MEDICAL EXAMINER USE ONLY

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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1

00131 600