

93039716

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 168

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

168-30-532-2 DECEASENT
Ph. Number called 6-31-93

1 DECEASED—NAME (First Middle Last) Roosevelt Abernathy		2 SEX Male	3a TIME OF DEATH 1:10 P.M.	3b DATE OF DEATH (Month Day, Yr) June 10, 1993
4 SOCIAL SECURITY NUMBER 312-10-3866	5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) April 19, 1914
7 BIRTHPLACE (City and State or Foreign Country) Houlka, Mississippi	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? -----	9a 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	
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) Clara Hobson	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Operator (Retired)	12b KIND OF BUSINESS/INDUSTRY LTV Steel	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION East Chicago	13d STREET AND NUMBER 3708 Catalpa Street	
13e ZIP CODE 46312	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify) Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)		
18 FATHER'S NAME (First Middle Last) Jake Abernathy		19 MOTHER'S NAME (First Middle Maiden Surname) Kattie Buggs		
20a INFORMANT'S NAME (Type/Print) Clara Abernathy		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 Catalpa St. East Chicago, Indiana		20c Relationship Wife
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) June 11, 1993 Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana
22a EMBALMER'S NAME Tracy Cheri Williams		22b EMBALMER'S LICENSE NO. FD08600238	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b LICENSE NUMBER (of Licensee) FD08600238	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Hinton-Williams Funeral Home FH030015 4859 Alexander Ave. East Chicago, In.	
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. Sublethal hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (Final disease or condition resulting in death) ASCVD		DUE TO (OR AS A CONSEQUENCE OF)		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last COPD		DUE TO (OR AS A CONSEQUENCE OF)		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no		28. WAS AUTOPSY PERFORMED PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) no
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>		29c MEDICAL LICENSE NO. 01032690
29d DATE SIGNED (Month Day, Year) 6-10-93		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Sami Ahmadi, M.D. 6933 Kennedy Hammond INDIANA		
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month Day, Year) 6-11-93		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		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) 600
34g DATE PRONOUNCED DEAD (Month Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 01335		

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

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FILED JUN 27 1993