2C

Charles D Bates Jr.
5557 Broadway
Merr., Ind

4/2/1?

Local No. 89-0283

93042397

Key#46-551-46
Marshalltown Terrace
L46 BL3

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST: Jimmie MIDDLE: Lee LAST: Ambrose
2. SEX: F
3. DATE OF DEATH (Mo. Day Yr.): 5-10-89
4. SOCIAL SECURITY NUMBER: 427-64-0500
5a. AGE—Last Birthday (Years): 64
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Month Day Year): 10-4
7. BIRTHPLACE (City and State or Foreign Country): Holly Spring, Miss.
8. YEAR LAST SERVED IN US ARMED FORCES?: NO
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☑ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist North Lake
9c. CITY, TOWN OR LOCATION OF DEATH: GARY
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): Louis Ambrose
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired):
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: IND.
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 2570 East 22nd Ave
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE:
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: ☒ No ☐ Yes
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+): 2

PARENTS

17. FATHER'S NAME (First, Middle, Last): John Wesley Williams
18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Louis Ambrose
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2570 East 22nd Ave
19c. Relationship:

DISPOSITION

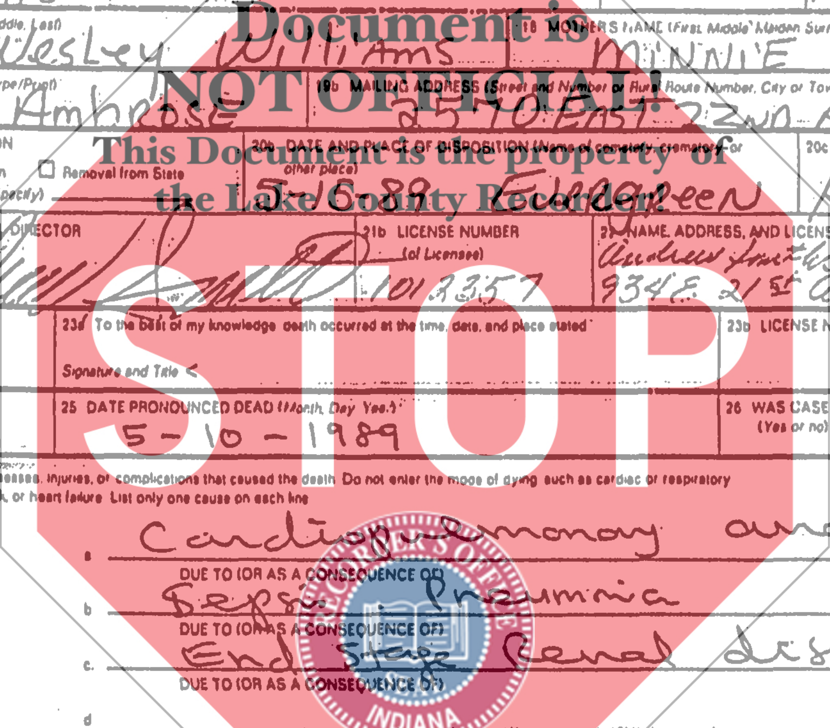
20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 5-16-89 Evergreen
20c. LOCATION—City or Town, State: Hobart IND
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): 1012357
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Andrew Smith Funeral Home 9348 21st Ave ... 2551

PRONOUNCING PHYSICIAN ONLY

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)

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

24. TIME OF DEATH: 8-50 AM
25. DATE PRONOUNCED DEAD (Month Day Year): 5-10-1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
JUN 30 10 35 AM '93
RECORDER

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Sepsis Pneumonia
DUE TO (OR AS A CONSEQUENCE OF)
c. End Stage Renal disease
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

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Gastro-intestinal Bleeding

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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: [signature] DeKumar
29c. LICENSE NUMBER: 6576
29d. DATE SIGNED (Month, Day, Year): 5-11-89

FILED

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]

JUN 30 1993

32. DATE FILED (Month, Day, Year): MAY 11 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)

Anna N. Anton
AUDITOR LAKE COUNTY

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