3vets
1total

93056720

93- 0252

Local No. ....

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Roy Lee DeLoach
2. SEX: Male
3a. TIME OF DEATH: 1:30 PM
3b. DATE OF DEATH (Month, Day, Year): April 2, 1993
4. SOCIAL SECURITY NUMBER: 423-18-8914
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): February 18, 1917
7. BIRTHPLACE (City and State or Foreign Country): Kennedy, Alabama
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): HOSPITAL: XX Inpatient ☐ ER Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
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): Mary M. Mitchell
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pusher Operator
12b. KIND OF BUSINESS/INDUSTRY: USX (Coke Plant)
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2568 Jefferson Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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) / College (1-4 or 5+): Unknown

PARENTS

18. FATHER'S NAME (First, Middle, Last): Guy DeLoach
19. MOTHER'S NAME (First, Middle, Maiden Surname): Wilhemina Unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary M. DeLoach
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2568 Jefferson Street Gary, Indiana 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 7, 1993 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO.: #01051696
23. WAS DEATH REPORTED TO CORONER? XX 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 & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Pneumonia —
DUE TO (OR AS A CONSEQUENCE OF):
b. Stroke —
DUE TO (OR AS A CONSEQUENCE OF):
c. Arteriosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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
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): XX 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: R H Hovanessian MD
29c. MEDICAL LICENSE NO.: 01033583
29d. DATE SIGNED (Month, Day, Year): 4/6/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print): Dr. Hovanession 7865 Broadway Merrillville, IN 46404

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): APR. 8 1993

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.

FILED AUG 30 1993

Anna M. Antonich
AUDITOR LAKE COUNTY

1851

SDH06-004 State Form 10110 (R/1-92) DEATHCER/PD

Verify Oak Park ADD L18 B1 4 2 46-155-17

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CERTIFIED BY
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE APR. 8 1983